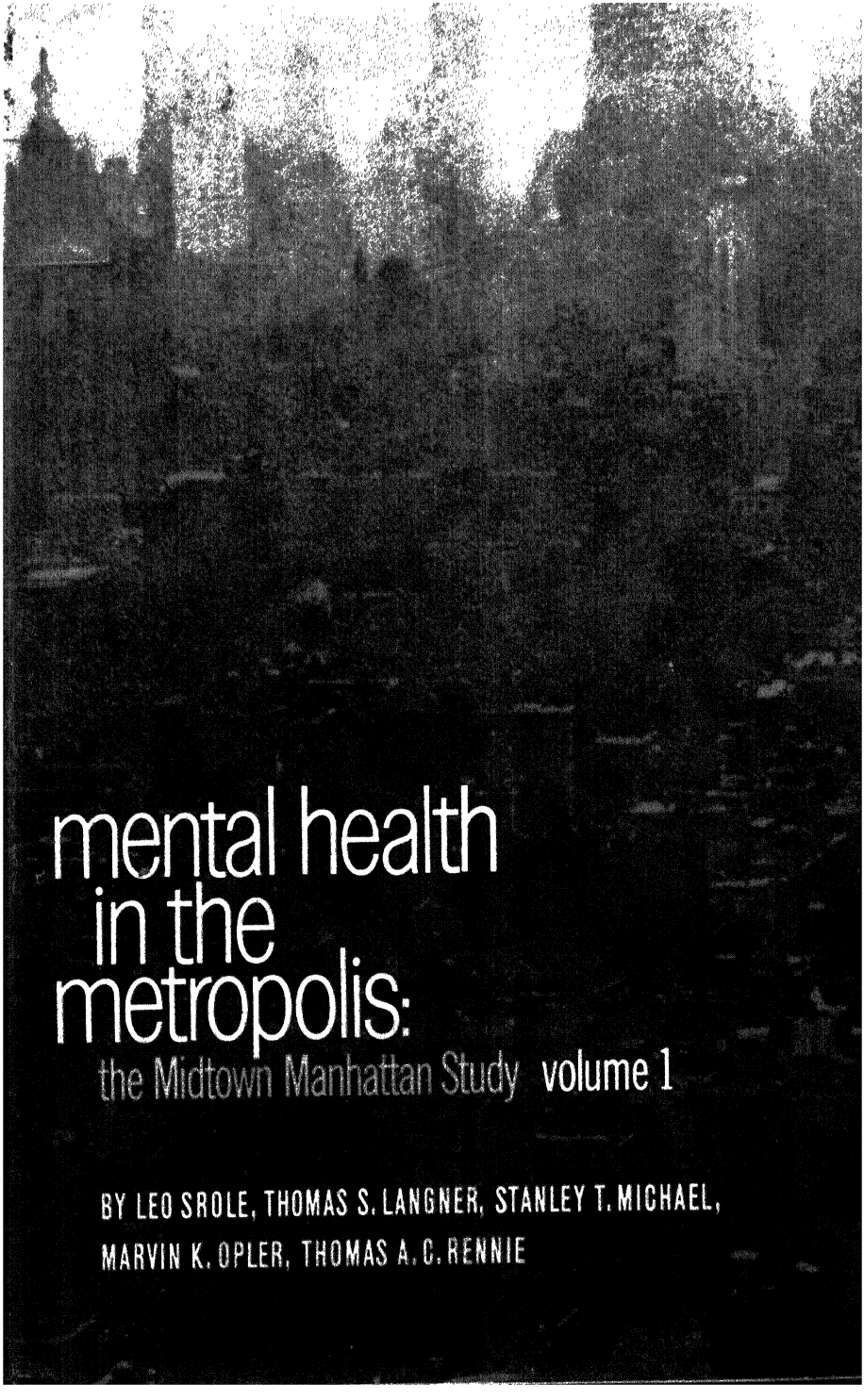

mental health in the metropolis:

the Midtown Manhattan Study volume 1

BY LEO SROLE, THOMAS S. LANGNER, STANLEY T. MICHAEL,
MARVIN K. OPLER, THOMAS A. C. RENNIE

Two of the many fine comments made about this outstanding book:

"I believe the Midtown Project is the best prevalence study of behavior disorder in the United States."

F. C. Redlich, M.D.
Professor and Chairman, Department of Psychiatry, Yale University School of Medicine

"I have no doubt that *Mental Health in the Metropolis* will become an enduring classic in its field."

Alexander H. Leighton, M.D.
Cornell University Medical School

By

Leo Srole, Ph.D.
Thomas S. Langner, Ph.D.
Stanley T. Michael, M.D.
Marvin K. Opler, Ph.D.
Thomas A. C. Rennie, M.D.

Foreword by Alexander H. Leighton, M.D.

The first volume of a three-volume series known as the Thomas A. C. Rennie Memorial Series In Social Psychiatry, this work is the fruit of a major effort in a new field of psychiatry. The volumes in this series are based on the eight-year research study of the Midtown section of the population of Manhattan.

New York is capital and market place for the world, and Manhattan is the City's crossroads, workshop, and playground. Better than any other metropolis in history, perhaps, this Island's face is known to people the world around through the imagery projected by the various entertainment and information channels.

In this book Manhattan, for the first time, comes under the collaborative scrutiny of a

(Continued on back flap)

3 1148 00360 6944

132 Mo29 v.1 03-00242
The Midtown Manhattan study

kansas city public library
kansas city, missouri

Books will be issued only
on presentation of library card.
Please report lost cards and
change of residence promptly.
Card holders are responsible for
all books, records, films, pictures
or other library materials
checked out on their cards.

Mental Health in the Metropolis

The Midtown Manhattan Study

DATE DUE
APR 1963
MAY 27 1966
DEC 2 1966

Leo Srole, Ph.D.
Professor of Psychiatry (Sociology),
State University of New York Medical Center (Brooklyn)

Thomas S. Langner, Ph.D.
Assistant Professor of Sociology (Psychiatry),
Cornell University Medical College

Stanley T. Michael, M.D.
Research Associate in Psychiatry, Cornell University Medical College

Marvin K. Opler, Ph.D.
Professor of Social Psychiatry, University of Buffalo School of Medicine

Thomas A. C. Rennie, M.D.
Late Professor of Psychiatry (Social Psychiatry),
Cornell University Medical College

THOMAS A. C. RENNIE SERIES IN SOCIAL PSYCHIATRY
Volume I

Mental Health in the Metropolis

the Midtown Manhattan Study

By Leo Srole
Thomas S. Langner
Stanley T. Michael
Marvin K. Opler
Thomas A. C. Rennie

Foreword by Alexander H. Leighton

The Blakiston Division · McGRAW-HILL BOOK COMPANY, INC.
New York Toronto London

MENTAL HEALTH IN THE METROPOLIS
The Midtown Manhattan Study

Copyright © 1962 by the McGraw-Hill Book Company, Inc. Printed in the United States of America. All rights reserved. This book, or parts thereof, may not be reproduced in any form without permission of the publishers.

Library of Congress Catalog Card Number: 61–13171

60570

To the Memory

of

THOMAS A. C. RENNIE, M.D.

February 28, 1904–May 21, 1956

Late Professor of Psychiatry (Social Psychiatry)

Cornell University Medical College

Founder and First Director

of the

Midtown Manhattan Mental Health Study

Foreword

The Rennie Series, of which this volume is the first, is the fruit of a major effort in a new field of psychiatry. Prior to the last war, a few behavioral scientists had for some time been interested in the effects of social and cultural environment on mental health, but within psychiatry itself relatively little attention had been paid to the subject. There were, of course, some exceptions to this, a notable one being Adolf Meyer.

After the war a number of research projects concerned with understanding the socio-cultural aspects of etiology in psychiatric disorder came into existence. Some gave emphasis to the significance of cultural differences and some to the patterns of stress and strain in modern living, as exemplified in the industrial setting or as mediated through the family.

This upsurge of interest was undoubtedly influenced by the war. The reasons were manifold; some were diffuse and part of the general shaking up experienced by people everywhere; some reflected greater awareness of the severe emotional problems confronting mankind in a changing society. Another factor was the apparently high prevalence of psychiatric disorder found in the course of selection for military service. Moreover, psychiatrists, in caring for the health of military units rather than individuals only, noticed striking differences evidently due to conditions of living, battle, and morale and were confronted with the problems of rehabilitating those who had been psychiatrically disabled.

Thomas A. C. Rennie was one of those in the forefront of this interest and endeavor. A graduate of Harvard Medical School and with three years of training in internal medicine, he studied psychiatry under Adolf Meyer at Johns Hopkins in 1931. While at Hopkins he was mainly interested in therapy and teaching, yet he devoted some time to a study of schizophrenia and produced a book on the subject. In 1941 he accepted a position as Associate Professor in the Department of Psychiatry at Cornell University Medical College in New York. Here, in addition to his teaching and clinical duties, he was drawn into activities connected with the war, serving, for example, on the Army Advisory Committee of Greater New York. This led naturally to an interest in veterans, especially in their rehabilitation; and this in turn brought him into contact with many community problems and projects. At one time or another he was Director of the Division of Rehabilitation, National Association for Mental

Hygiene; Chairman of the Professional Committee, National Association for Mental Health: Member of the Board of Trustees, American Foundation for Mental Hygiene; Chairman of the New York Community Mental Health Board; Coeditor of the *International Journal of Social Psychiatry;* and Consultant in Psychiatry at the Franklin Delano Roosevelt Veterans Administration Hospital, Montrose, New York. He was coauthor of two books, *Mental Health in Modern Society* and *Jobs and the Man*, as well as of numerous articles that reflected these activities and interests. (References for these publications may be found in Appendix B.)

Under the stimulus of such work, Rennie conceived the Midtown Project and began its planning early in 1950. He was given the full and imaginative support of Professor Oskar Diethelm of the Department of Psychiatry, Cornell University Medical College, and later in the same year he was appointed Professor of Psychiatry (Social Psychiatry), the first such position in the United States, so far as is known. Rennie visualized the project first in very broad terms as aimed at the study of the extent of mental disorder and of resources that might be needed, and as concerned with some experiments in public education. His Charter Day Address at the New York Hospital on May 9, 1950, constituted a preliminary formulation of the project.

It required two years of steady effort before the project was adequately financed and fully under way as a research operation. The fact that such an original, massive, and expensive study came into existence at all is evidence of Rennie's persistence, tact, and enthusiasm. Recognizing the interdisciplinary nature of the task, he turned to a number of consultants. In later years he frequently mentioned the debt he felt he owed to them and, indeed, wrote out a retrospective statement to this effect. The particular individuals are accordingly noted in the author's acknowledgments (Appendix A) of this book, but it seems fair to say here that Rennie himself possessed a rare capacity to make use of the variety of advice and recommendations he received and to synthesize them into something that was his own.

On May 21, 1956, Rennie died from a cerebral hemorrhage. This was a sad loss deeply felt by his many friends. It was also a loss from which the Midtown Manhattan Project could not fully recover. Fortunately all the field work of the study had been accomplished, so that what remained was a major part of the analysis and the reporting of results and their implications.

The primary members of the Midtown Project who were available to continue the work on a full-time basis were Professor Leo Srole, a sociologist, Professor Marvin K. Opler, an anthropologist, and Professor Thomas S. Langner, a sociologist. Those available only part time were Dr. Price Kirkpatrick and Dr. Stanley T. Michael, the two psychiatrists who, with Rennie, had carried out the clinical aspects of the work. Be-

cause of my previous association with the project as a consultant to Rennie, and because I was engaged in the Stirling County Study, which had somewhat similar objectives, I was asked by Dr. Diethelm to help finish the work. The position was defined as director and coordinator, rather than as an author.

From 1956 until the present, the analysis and reporting went forward with the main load of writing being carried by the social scientists. The psychiatrists, particularly Dr. Michael, acted as discussants and critics, especially with reference to the clinical viewpoint. Many pages were written on particular topics and later absorbed into the body of the document. Because of differences in orientation stemming from their various disciplines, the authors had to spend much time in working through to mutual understanding and hammering out acceptable modifications. The completion of this volume is a testimony to their patience and determination.

Implicit in the analysis was the need for many decisions on appropriate targets for investigation. While the design of the field work as established by Rennie defined certain objectives and set limits to subsequent analysis, the range of data obtained was so extensive and the number of possible questions and conclusions that could be investigated so enormous that successive choices had to be made in order to keep the project within the bounds of the attainable. Added to this was the nature of the findings themselves and the promptings they gave to emphasize one rather than another line of thought and interest. As a result of these conditions and influences the work bears the stamp of much that has transpired since Rennie's death. It probably differs in many respects from what he would have done, and it undoubtedly lacks qualities which his genius would have contributed. We hope, however, that he would have been pleased with it and that the volumes as a whole are a suitable memorial to his vision, his zest for living, and his compassion for humanity.

Rennie left behind no specific drafts for any portion of this volume, with the exception of the first chapter. Some time in the spring of 1956, knowing that his life might not extend much longer, he wrote out what he intended to say at the beginning of the book. This is not now entirely apposite to the volume, nor can we think of it as what he would write if he were living today. Nevertheless, since it shows many of his outstanding qualities, and since it is the last word we have from him, it is given exactly as he set it down.

ALEXANDER H. LEIGHTON, M.D.
Professor of Psychiatry (Social Psychiatry)
Cornell University Medical College

Contents

Foreword vii

PART I—Prologue

1 Reasons for the Study 3
2 Goals and Guidelines of the Study 8
3 Study Methods: Design 26
4 Study Methods: Mental Health Ratings 59

PART II—Midtown Portrait

5 The Scene and the People 69
6 Population Distillates 88
7 Community Institutions and Psychosocial Climate 104

PART III—Midtown Mental Health Composition and Psychiatric Care

8 Midtown and Several Other Populations 127
9 Age Groups 157
10 Sex and Marital Status Groups 174
11 Socioeconomic Status: Specifications 190
12 Socioeconomic Status Groups: Their Mental Health Composition 210
13 Socioeconomic Status Groups: Their Psychiatric Patients 240
14 Generation-in-U.S. and Rural-Urban Origins 253
15 National-Origin Groups 282
16 Religious Origin 300

PART IV—Epilogue

17 Psychiatrist's Commentary 327
18 Sociologist's Sight Lines: Retrospective and Prospective 336

PART V—Appendixes

A Acknowledgments 375
B Thomas A. C. Rennie's Publications in Social Psychiatry ... 378
C Incidence versus Prevalence of Treated Mental Illness ... 380
D Further Checks of Home Survey's Sample of Respondents 383

E Interview Summary Form for Study Psychiatrists 388
F Additional Information on the Mental Health Ratings 395
G Characteristics of Midtown Compared with other Populations (Based on United States Census of 1950) 408
H Errors, Artifacts, and Biases in the Mental Health Distributions among SES-Origin Groups 411

Index 415

PART I

Prologue

CHAPTER 1 *Reasons for the Study*[1]

Thomas A. C. Rennie

The fact that a few psychiatrists are now looking to the community for the answer to some of the problems of mental illness and their causation is a logical outgrowth of the development of psychiatry itself. The psychiatrist as a physician is traditionally trained in the intensive study of a given individual—his biological make-up, his personality structure, his family background, and all areas of his life, such as education, occupation, marriage, sexual strivings, ambitions, and disappointments. In the study of a given individual, the method used is the biographic one, which gives particular attention to the series of life events beginning with birth and extending throughout the life span. Much attention is given to childhood events as being of major importance in determining the prevailing patterns of reactions, feelings, attitudes, and ways of interpersonal reacting.

As psychiatry has grown in knowledge of general psychopathology and its causation, more and more time is required in the preparation of the psychiatrist for the mastery of this extensive body of data. The young psychiatrist must also develop tools of interviewing and communication and must sharpen his sensitivity to the overtones and undertones of the patient's utterances. He must master an array of techniques for the study of personality, as well as develop skills in the therapy of disturbed persons. He sometimes uses physiologic methods, chemicals, and other procedures, but the main tool with which he must acquire skill is that of psychotherapy. This gives him little time in the three basic years of his training to explore the world beyond the hospital or the clinic or to engage himself in the broader aspects of his eventual role as a member of the community, both as a citizen and as a therapist.

All too soon the average psychiatrist finds himself drawn into a variety of functions in the community wherein his skills are called upon for interpretation, for public education, for preventive services, and for community leadership. He soon finds that a great many people have an intense interest in the problems of mental health and that persons other

than psychiatrists have a vital role to play in the promotion of sound mental health, the provision of good hospital treatment, and the increasing creation of preventive services. Very soon he finds that other intelligent and thoughtful people need to profit by his insights so that they may perform their functions more wisely. He soon finds his advice sought by such diverse groups in the community as lawyers and judges seeking to administer the law with constructive wisdom, ministers seeking to advise and counsel with some basic understanding of human behavior, teachers trying to educate the whole person toward the end of sound personality and character development, doctors and public health nurses who must deal every day with sick and emotionally troubled people, and intelligent groups of lay persons bent upon strengthening the adaptive capacities of the people—notably groups such as parent-teacher associations, men's and women's clubs, neighborhood houses, boys' clubs, the Red Cross, and the Travelers Aid Society. As a result of the phenomenal growth of public interest in psychiatry, the enormous number of magazine articles and books written for lay audiences on that subject, and the growing interest of creative artists in the contributions of Freud and other pioneers in psychoanalysis, we in the United States are now witnessing the growth of a great many lay citizen groups banded together for knowledge and action. This development of the mental health movement began with Clifford Beers and progressed for forty years to the establishment of the National Association for Mental Health, together with countless state and community mental health organizations. We have reached the point in psychiatric development where many psychiatrists feel deeply impelled to turn their interest outward from the individual patient to the family, the community, and the total cultural scene. Some of these developments and the way in which allied professional and nonprofessional people can be helpful have been sketched by the author in a prior publication, *Mental Health in Modern Society.*[2]

We are witnessing at present in this country a steady increase in programs for public education in mental health matters. Unfortunately much of this activity is conducted in a vacuum, since we know all too little of what people know and do not know about mental health, what personal anxieties lie behind their resistance, what prejudices and misconceptions stand in the way of their learning, and what anxieties may be stirred up in them by the very attempts at education which are undertaken so enthusiastically and vigorously. In actuality we know that there is an enormous misunderstanding of all matters pertaining to mental health on the part of great segments of the American public. The study conducted in Louisville, Kentucky, by Elmo Roper and associates[3] and a nationwide survey of public attitudes by Shirley Star[4] give clear indication that great confusion prevails, that most people have literally no

understanding that mental illness is an illness, and that fewer yet have any idea of when help is needed or where it can be found.

Clearly, mental health educators need to ask themselves a few basic questions: Who is being educated? What do they want and need to know? What is the proper time for the presenting of information? What is the effect of the information given? What are the best tools for the dissemination of mental health information? Much genuine basic research remains to be done in this area.

A second major problem which faces public health officials throughout the country is that of determining what resources are needed for the treatment of mental health problems in a given community. Certainly the most reliable findings are those of Roth and Luton[5] and Lemkau, Tietze, and Cooper[6] in two field studies made to determine the prevalence of mental health disorders. The study undertaken in the Midtown area of Manhattan by the authors should supplement these earlier ones. It indicates that the need for health services is far greater than has been previously realized. Therefore, similar studies should prove valuable in planning the services required by a given population group. They not only should determine this on the basis of the total number of persons likely to need psychiatric help, but should give real indication of the relative amount of help needed by various subgroups. It is very likely that, as Buell and associates[7] found in Minneapolis–St. Paul, a consistently small portion of the population will regularly utilize the majority of the health services. In that particular instance, approximately one-quarter of the population regularly and consistently utilized four-fifths of the available health resources.

It is known that frequent physical illness is commonly associated with a high incidence of psychiatric disorder. Furthermore, we have come to know that psychoneurotic and psychosomatic illness occurs in clusters within certain families and that such persons and families can be identified.[8] This clearly points the way to preventive psychiatry at its best. If programs of prevention in the field of psychiatry are to become workable realities, they must be based on family and community studies which indicate the danger areas, the problem persons in families, and the kind of resources needed for a truly preventive program.

We must realize that psychiatric disorder occurs in persons nurtured in a particular family constellation and living in a highly specific sociocultural environment. In the field of delinquency and antisocial behavior this point of view generally prevails, and the research worker in these fields is apt to put stronger emphasis on the understanding of the total cultural environment. However, the fact that certain sociocultural environments may well be conducive to a higher incidence of psychiatric disorder is not generally known. If psychiatry is truly to move into a vigorous

period of real preventive work, it must begin to look beyond the individual to the forces within the social environment which contribute to the personal dilemma.

Thus it appears that the time has come to establish a working relationship between the social scientist and the psychiatrist; their cooperation will inevitably lead to new possibilities of research into human behavior

To set up research projects such as the one reported in this volume in a field so vast, encompassing so many variables, is a formidable task; it has only recently been undertaken by a scant dozen investigators determined to define methodologies and come to grips with the endless facets of the problem. The research group faces the difficulty of dealing simultaneously with the whole set of operational forces, while keeping the major ones clearly in mind and attempting to reduce the task to encompassable limits. Such a team must first come to understand each other's discipline and become acquainted with the major theories, hypotheses, and facts of each; they must cross the semantic barrier of technical language which often obscures each member's contribution, even though the team ultimately comes to understand that they are often talking about the same phenomenon obscured by overly specific linguistics.

The next step is the pooling of all relevant data for the formulation of a set of testable hypotheses which can then be reduced to a specific research design. In our project a set of 61 research hypotheses dealing with sociocultural factors and mental illness was derived.

The formula finally arrived at places psychiatric disorder and intrapsychic malfunction as a set of dependent variables. The independent or relatively fixed variables are those of cultural background, socioeconomic status, ethnic identification, and the attributes of urban-rural living. In our own urban study we are concerned with the many variables imposed by urbanism itself—density, heterogeneity, secularism, isolation, anonymity, and spatial, vocational, and social mobility, as well as the whole range of unforeseen experiences that befall man in terms of exogenous disease and physical malfunction. We hypothesize that these factors are significant for personality stability or maladjustment.

To forge tools and instruments to accumulate systematically such data on cross sections of the population is one task of a social psychiatrist. In psychiatric practice we see mainly the top of the iceberg—the known sick —those who seek help. Social psychiatry must concern itself also with the submerged part of the iceberg—those persons in society who never seek psychiatric therapy or who find no such help available. To this end, therefore, the social psychiatrist's methodology must include techniques for the systematic psychiatric study of a sample of persons in a given community. Because of the very nature of the task his psychiatric tools will be less sharp than in the hospital or office, since it is manifestly im-

possible to conduct deep psychiatric explorations of such a sample. He must rely heavily on validated psychological tests and questions. Furthermore, he must profit by the experience of the statistician, who will help him to draw a workable sample which will presumably be representative of the whole. In our own study a rather far-reaching questionnaire method was utilized for the study of individuals selected at random and of sufficient number to permit generalizations. It was administered by experienced, clinically trained persons with psychiatric social work and clinical psychology backgrounds.

The findings of the various similar researches contemporaneously under way in such different settings as rural Nova Scotia, urban Syracuse, New Haven, New York, and Baltimore and the possibility of sharing and comparing such diverse data should enable us to move forward in the understanding of the total forces significant in human adaptation.

This book, then, is the story of one such community research project which will attempt to define the problem, give a picture of our struggles to arrive at the appropriate methodologies, and report the findings of our community studies in *Midtown,* an area of New York City unequaled for its heterogeneity and diversity of urban living.

FOOTNOTES

[1] Taken in part from Thomas A. C. Rennie, "Social Psychiatry: A Definition," *Intern. J. Social Psychiat.,* vol. 1, no. 1, 1955.

[2] Thomas A. C. Rennie and Luther E. Woodward, *Mental Health in Modern Society,* The Commonwealth Fund, 1948.

[3] Elmo Roper, *People's Attitudes Concerning Mental Health: A Study Made in the City of Louisville,* 1950.

[4] Shirley A. Star, "The Place of Psychiatry in Popular Thinking," an address given to the Annual Meeting of the American Association for Public Opinion Research, May, 1957.

[5] William F. Roth and Frank B. Luton, "The Mental Health Program in Tennessee," *Am. J. Psychiat.,* 99, 1943.

[6] P. Lemkau, C. Tietze, and M. Cooper, "Mental Hygiene Problems in an Urban District" (three papers), *Mental Hyg.,* vol. 26, no. 1, January, 1942; *Mental Hyg.,* vol. 26, no. 2, April, 1942; *Mental Hyg.,* vol. 27, no. 2, April, 1943.

[7] Bradley Buell, "We Know Better Than We Do," *The Survey,* vol. 187, no. 121, pp. 533–535, December, 1951.

[8] Jean Downes and Katherine Simon, "Characteristics of Psychoneurotic Patients and Their Families as Revealed in a General Morbidity Study," *Psychosomat. Med.,* vol. XV, no. 5, pp 463–476, September–October, 1953.

Jean Downes, "Chronic Disease among Spouses," *Milbank Mem. Fund Quart.,* vol. 25, no. 4, pp. 334–358, October, 1947.

Jean Downes, "Social and Environmental Factors in Illness," *Backgrounds of Social Medicine,* Milbank Memorial Fund, 1949, pp. 64–83.

CHAPTER 2 *Goals and Guidelines of the Study*

Leo Srole

By measure only of calculable dollar costs drained from national income,[1] mental illness stands charged as the gravest public health liability of our time. By duration of its creeping blight over the victim's life span, mental illness must additionally be arraigned as the most insidious of human afflictions. It is ironical, in this light, that in magnitude of the research counterattack mounted against it mental disorder remains one of the most neglected of our public health problems.

These observations may suggest something of the pressures upon science to engage the problem on an all-out alarm basis. The Midtown Manhattan Study, reported in these pages and in two companion volumes to follow, represents one among many research responses to those pressures.

The reader, whether layman or professional, is here invited to participate in that response retrospectively. Sharing this experience in the form of a discourse with the reader, we will present not only certain findings of the Study, but also the operations that produced these results, and even the scientists' caveats on the imperfections and limitations of their data. To adapt Cervantes' analogy, "proof of the pudding" is not in the eating alone, but also in the review of the chef's recipe and how it was actually followed.

Forbearance is therefore solicited from the wayfarer through these pages. From the general reader we beg forbearance for shoptalk that is of interest mainly to the professional and is confined in large part to Chapters 2, 3, 4, and 8. From the professional reader, on the other hand, we ask indulgence for our attempt to distill fundamentals of his field, necessarily oversimplified, for those of other special backgrounds. Reflected in the fare here hopefully set out, then, is diversity among the expected guests.

The challenge before science to confront, contain, and ultimately roll back mental illness is urgent and many-sided indeed. From one direction comes the insistent call for *program research* to guide public and professional policy in mobilizing the treatment fronts of the problem. This

need has been spelled in deceptively elementary terms by the Medical Director of the National Institute of Mental Health.[2]

> How many people in the United States actually are mentally ill? How many mental health clinics do we need? How many psychiatrists? How many psychiatric nurses? All of these questions are reasonable and important. Yet to none of them can we give a firm answer, based on tried and tested facts.
>
> It may be argued that, since the deficiencies in service personnel and facilities in this field are so obvious and so great, why bother collecting data to prove what is already known?
>
> This argument is not valid. We have the problem of allocating scarce resources and must find areas of greatest need. The very complexity and vastness of the problem make it imperative that we get the best possible data upon which to base our action programs. . . . Our great need is for facts—many facts, accurate facts. . . .

From another direction comes the equally insistent demand for *basic research,* to wrest new knowledge, without regard to program utility, about the still elusive mainsprings of most mental-disorder processes.

Both calls were cardinal points of orientation to Rennie, the writer, and our research colleagues through the entire course of the Midtown Study. However, the need for basic research claimed by far the greater part of available energies and resources and will receive corresponding attention in the pages of this monograph.

As in the case of the still-unknown causation or pathogenesis or etiology of most cancer types, the magnitude and complexity of mental disorder dictate an over-all strategy of probing attacks along the entire horizon of theoretically promising approaches. Rennie's choice of specific approach to be taken in the Midtown Study is suggested by the composition of the research staff which he, as directing clinical psychiatrist, assembled in June, 1952. Joining him originally were representatives from the fields of sociology, psychiatric social work, clinical psychology, and anthropology.

For over a year, this multiprofessional team functioned as a committee of the whole and through special subcommittees in the processes of decision making on two levels of project planning. On the first level, the Study's objectives, working concepts, and test hypotheses were provisionally formulated to steer the investigation on its course. The general outlines of the conceptual framework which was developed, and the problems it posed, along with analytical schemes later elaborated to order the data, are sketched in the present chapter.[3]

On the second level of planning, the research design, procedures, and instruments were forged to implement the conceptual framework adopted. These are outlined in the two chapters that follow.

During the conceptualizing phase of staff planning, interdisciplinary difficulties inevitably arose. Several of these are worthy of brief mention

here, only because the resolutions reached are suffused through the pages of this monograph. One problem hinged on the specialized technical terminology employed by each scientific discipline and the tendency to view the professional language of every other science but one's own as jargon. It was decidedly our experience that in most instances team collaboration ultimately bridged such gulfs.[4]

Nonetheless, as a collaborative product of several sciences the present monograph of course draws upon the technical vocabularies of all participating disciplines. It does so by the sheer necessities of its task and by an aversion to the deceptive façade of "popular science prose."

Semantic hurdles aside, among its collaborating disciplines the research group also encountered inevitable differences in theoretical points of emphasis. Such divergences among more distantly related disciplines were further complicated by differences, sometimes striking, between representatives of the same or closely related disciplines. The principle underlying the effort to overcome such barriers on the part of Rennie and most team members has been expressed in a notable paper that happened to touch on intradisciplinary contention in psychiatric research. The relevant observation is this: "It is earnestly to be desired that in this difficult field, questions of absolute truth and universal validity be set aside and attention concentrated upon the experimental study of working hypotheses and provisional concepts."[5]

Linking this and all subsequent chapters is the keynote that the goals sought and concepts applied in the Midtown Study were provisionally tailored to the limiting realities of what was operationally achievable, rather than to what would have been theoretically ideal in the emphatic view of one or another scheme of thought. For this reason, among others, the Midtown Study must affirm that it is an exploratory, rather than a definitive venture in basic research. For its large questions it can secure only limited answers, but these, hopefully, may provide grounds for framing new or more specific research questions.

The results of this exploratory effort await the reader's judgment about the data chapters that follow presently. For his later convenience, moreover, the results there set down are summarized and evaluated in Chapter 18.

RESEARCH APPROACH AND FOCUS

The multifaceted research approach brought to bear in the Midtown Study is hardly novel. Historically viewed, however, it is seen to represent a recent convergence of three independent streams of scientific development.

One strong current in this confluence flowed from the discipline of medical epidemiology, a research arm of preventive medicine. In briefest

compass, medical epidemiology can be defined by its focus on "the origin and course that disease takes in population groups." [6]

A historian of the field records that, although "originally concerned only with epidemics, its scope was extended first to include infectious diseases which do not ordinarily occur in epidemic form, such as leprosy, syphilis, and tuberculosis, and later to non-infectious diseases." [7] The latter included the diseases of nutritional deficiency (beriberi, pellagra, and scurvy), metabolic disorders, and cancer, among others.

Epidemiology traditionally has rested on the concept of *ecology*, under which disease is observed from the perspective of populations as they are affected by their environments. However, Gordon[8] adds that until nearly the end of the period of sole concern with the infectious diseases, roughly coinciding with World War I, epidemiology was heavily preoccupied with the bacteriological agents to the neglect of research into other environmental contributions to disease. The turning point came when it was realized that with this one-sided emphasis, "the question of why epidemics come and why they go was little better defined than before." Doull [9] describes the shift as a recognition that, although "the occurrence of an infectious disease is determined by a dosage of pathogen sufficient to overwhelm resistance of the human host, there are social and economic factors which may cause, augment or prevent exposure and which may raise or lower resistance." Evidence has been noted, for example, that while tubercle bacilli are widely disseminated in the population, the disease itself tends to be narrowly concentrated in certain small social segments of the community.

With the push of epidemiological research into the noninfectious chronic disorders came greater awareness of "the social component of environment [as] that part which results from the association of man with his fellow man [including] the attainments, beliefs, customs, traditions, and like features of a people [that] range from housing to food supply; and from education to the provisions made for medical care." [10] The more specific contributions of medical epidemiology to the evolution under review here will be considered presently.

Psychiatry has historically followed two main avenues of research development. The first moved into the organic preconditions and corollaries of mental disorder from various separate points of departure in the human system, including heredity, neurology, endocrine function, metabolism, and electrophysiology.

To a certain extent independent of this biological or somatogenic approach, the second avenue of psychiatric investigation examined the dynamic interplay of psychological processes and life experiences. However, with certain notable exceptions, the sociocultural environment that structures the family unit and envelops individual experience was not systematically taken into account and conceptualized within this psycho-

genic approach. Redlich, for example, has commented that in historical perspective "psychiatry has paid relatively little attention to the social environment and concentrated more on the exploration of organic and intrapersonal factors." [11]

Nonetheless, increasingly in recent years representatives of the psychogenic approach in psychiatry, like the medical epidemiologists, have been moving in this new direction, where they have met and joined the third scientific stream—itself with diverse origins in the social sciences. Included were sociology, with its long-pursued interest in the links between social-system pathology and such behavioral deviations as delinquency, suicide, and crime; anthropology, with its own particular emphasis on the global, normative view of both culture and personality; and social psychology, with its focus on the full range of behavior variability as related to specified interpersonal settings. In all three instances, these sciences had breached their original disciplinary dikes and were descending together on areas of direct concern to the expanding psychogenic approach in psychiatry and to the rather elementary sociogenic approach developing within medical epidemiology.

This convergence of psychiatry, medical epidemiology, and social science upon a common ground has appropriately come to be known as *social psychiatry*, paralleling the earlier emergence of biochemistry as the legitimate offspring of two previously discrete disciplines.

Some clinical psychiatrists, to be sure, have greeted the hybrid with such characterizations of social psychiatry as a "term full of sound and fury, signifying little." The present volume, like its research predecessors, attempts to define what one facet of social psychiatry actually signifies, at least in the operational terms of the research behaviors and output of one set of investigators. Also relevant is the literature that has been accumulating in the new field. For example, we now have accounts of early gropings by major figures in both psychiatry and the social sciences toward the untenanted no man's land stretching between them.[12] Adolf Meyer's part in this development was of particular importance, both directly[13] and through his students. Included among the latter are the psychiatrists Diethelm, Gruenberg, Leighton, Lemkau, and Rennie, all research contributors to the advancement of the new field. From another direction in psychiatry has come the weighty impact of such neo-Freudian theorists as Horney, Sullivan, and Fromm. There are also the significant crystallizations of thought in the work of the Committee on Social Issues of the Group for the Advancement of Psychiatry,[14] and of the Committee on Research in Psychiatry and the Social Sciences appointed by the national Social Science Research Council,[15] which Rennie had actively served as member.

Taking the approach of social psychiatry, the Midtown Study phrases the following general proposition as its most fundamental postulate:[16]

sociocultural conditions, in both their normative and their deviant forms, operating in intrafamily and extrafamily settings during childhood and adulthood have measurable consequences reflected in the mental health differences[17] to be observed within a population.

The Midtown investigators were acutely aware of the obstacles that awaited them on the scientific borderland marked by the above postulate, as well as of the limited objectives they could accomplish in the time available for the Study's mission. In a similar vein, Franz Alexander has commented: "The understanding of the dynamic interaction of the self with the social environment is in itself a goal [that] could occupy the productive capacities of generations to come." [18]

Before venturing into the far reaches of the social environment, the researcher, having rather less than one professional lifetime remaining to him, must first conceptually stake out the specific boundaries of the terrain he intends to explore. As a step in this direction, be it noted that the family, both to social science and to psychiatry, is the basic social unit and one of decisive relevance to their respective concerns. Placed in a larger frame of observation, however, the family is seen functioning in the nurturing medium of the surrounding community and its complex system of neighborhoods, groups, institutions, and friendship circles. Communities of course have their similarities and their differences. These differences become weighty indeed when communities are classified, among other possible ways, by the index of population size, e.g., on the rural-urban continuum ranging from the prairie "four corners" hamlet to the giant world metropolis.

Even in its presumably private functioning, the family presents open doors to the influences of the community which serves many of its elementary needs. Hence, it is a plausible postulate that any given big-city family is different, in gross and subtle respects significant for its members, from what it would have been had it settled in a small town.

Because it penetrates into the most intimate affairs of the family through direct impact on each member in extrafamily spheres of daily living, the local community in effect is forced upon social psychiatry as a necessary focus of study.

In so encompassing the community, social psychiatry is also following the example of medical epidemiology, its senior sibling research field. In the words of a medical epidemiologist, the community "extends the boundaries in which disease can be viewed beyond the ward or clinic. It provides a third dimension to the understanding of disease by creating awareness of the environment in which the disability arises, of the factors in the community which contribute to its causation, and in turn, its effect upon the community. . . ." [19]

In larger perspective, it has also been urged that "to attain a true concept of the national [mental health] problem we need studies . . . of

as many individual communities as possible . . . to be able to make comparisons between various geographic, socioeconomic and cultural areas of the country." [20]

The community population chosen for study here is described, and its larger significance is considered in Chapters 5 to 7. We designate it by the descriptive code name of *Midtown* and need only indicate now that in 1954 it numbered nearly 175,000 individuals settled in a sociogeographically well-delineated residential area near the epicenter of New York City's hub borough of Manhattan.

Our subject of study, then, is narrowed down to this particular metropolitan community, and the objective is to assess the fundamental but as yet generalized and seemingly obvious premise that sociocultural conditionings of its people are somehow implicated in their subsequent mental health fate.

The terrain marked out, the researcher starting toward such an objective finds himself immediately caught in the enormously tangled and slippery underbrush problems of causation. To guide his course over such treacherous ground, he usually carries in his equipment a general *modus operandi* for discerning antecedent-consequent links, if not direct cause and effect or etiology. Usually left implicit, this mode of inference deserves to be made explicit more often, at least in terms of its key assumptions.

The view applied here is essentially that developed in medical epidemiology and rests on the bedrock axiom that disease is an "output" reaction emerging from a complex of "input" conditions. More specifically, disease, like hurricane weather,[21] is the resultant of a number of factors that often vary independently of each other and converge to initiate, facilitate, or perpetuate a chain of atypical processes. Since the interactions among the several responsible factors upon convergence are often obscure, the specific traces of these factors in the disease process tend to be concealed from direct observation.[22] This is especially the case in the chronic types of disorders. For example, we are told that of the factors conducive to "hypertensive or arteriosclerotic cardiovascular disease almost nothing is known, although these two account for the great bulk of deaths from cardiovascular disease." [23]

Within such etiological darkness, the first "alert" signal that a particular factor may be implicated is evidence that in population groups where it is known to be operating the frequency of the disease is significantly higher than in groups where it is known to be absent. That is, the specific factor, when present, increases the risk that the disease will occur.[24] Such telltale evidence, if confirmed, establishes a relationship between factor and disease that is of the utmost importance, although remaining temporarily unknown may be (1) the specific mechanisms linking the two, and (2) the roles of other factors.[25] An illuminating case in point is pro-

vided by recent cancer studies: "It has been repeatedly shown that the greater the exposure to certain environmental factors the greater the risk of developing certain types of cancer. Though these factors may not be the only agents responsible for the induction of these cancers, in their absence the cancer incidence is greatly reduced." [26]

When several factors are separately found to be responsible for furthering a disease, they may next be investigated for the pattern of their interactions in the pathogenic process.

Two general types of etiological patterns in somatic disorders have been discerned. The first type seems to characterize the infectious diseases, where a microorganism, the responsible disease agent, requires several accessory conditions. Such accessory conditions would include circumstances in the physical environment facilitating or inhibiting the multiplication of the microorganism (e.g., climate), conditions in the social environment favoring or blocking its spread (e.g., sanitation) or affecting exposure (e.g., population density), susceptibility-immunity of individuals, etc.

Here each factor is a *necessary* but *not sufficient* condition, by itself, to produce the disease. This constellation might be characterized as *stable* in that more or less the same pathogenic conditions tend to recur in eliciting the illness.

The second type of pattern, probably involved in the degenerative disorders, is more fluid, in the sense that the same kind of malfunction and symptoms may be induced by different factors in diverse combinations. "That similar diseases may arise from dissimilar causes is established principle. . . . Examples are cirrhosis of the liver [and] appendicitis." [27]

In this type of configuration, the pathogenic factors may include one, or more, that is indispensable to the disease process, such as individual susceptibility. However, the remaining factors in the pattern are interchangeable, in the sense that preconditions A, B, and C may be operative in certain cases, D, E, and F in others, etc. Compared to the stable type, with its relatively few pathogenic factors, this pattern appears to be characterized by potential preconditions in larger number, variety, and combinations. Since many mental disorders seem likely to arise from this more fluid kind of emergent pattern, the analytical problems posed are of course far more complex.

In dealing with situation-response phenomena, it is customary to designate the antecedent conditions as the presumed *independent* variables and the consequence that follows, in this instance mental health, as the *dependent* variable, a distinction involving issues that will be considered presently. As to criteria and classification of mental health[28] itself, these are being reserved for special discussion in Chapters 3 and 4.

The two major orders of independent variables potentially capable of influencing mental health are the somatic and the sociocultural. The ques-

tion about the relative contributions of these two large sets of independent factors has long been a special case of the nature-versus-nurture controversy. The question has too often been addressed in the past, not as an empirical issue of extreme complexity, but as a debate from prefabricated platforms.

Our own tentative views on the matter can be briefly outlined in terms of the following assumptions:

1. In the individual patient it is etiologically important, of course, to delineate any organic foundations for the disorder. However, in the most prevalent, so-called functional illnesses this is often impossible.

2. In the population at large we can assume for mental morbidity that predisposition varies on a wide arc and may have diverse organic roots that will ultimately be circumscribed.

3. In the population at large we can assume for mental morbidity that intensification of predisposition and actual precipitation of illness vary in a wide span with the magnitude and character of pathogenic environmental intrusions.

4. Accordingly, it would follow that the mentally disturbed are etiologically heterogeneous to a high degree. At one extreme would be those in whom somatic vulnerability is maximal and the environmental contribution minimal. Bounding the other extreme would be those in whom organic vulnerability is minimal and the environmental impact maximal, as in certain traumas of military combat that can produce severe anxiety and pseudopsychotic reactions of a transitory nature. And stretching between would be all manner of balances in relative pathogenic weights.

Ultimately, research may be able to focus down to the interactions between specific somatic conditions and circumscribed sociocultural factors, as these jointly interpenetrate in the deeps of 'psychological processes. But it is our view that to make this possible, it is necessary *first* to isolate and identify such specific factors in each order of independent variable *separately*. This position led to the strategic decision to concentrate our research efforts on one of these orders.

In fixing on the social environment as the realm to be explored in the Midtown Study, the investigators, needless to say, did not thereby reflect a position of environmental determinism. In part, the decision grew out of an awareness of the fragmentary state of our knowledge both about the somatic realm as it shapes mental health[29]—including the psychosomatic disorders[30]—and about specific influences emanating from the sociocultural realm.[31]

Thus, the major limitation imposed on our data by this decision is that the contributory role of predisposing somatic factors in mental health will be largely untouched. This limitation, it may be added, represents a lack of analytical completeness that in one degree or other is inherent

in most exploratory investigations with disease etiology as their target and a relatively short life expectancy as their outlook.[32]

THE TEST FACTORS

Under the limited time available to it, the Midtown research project was planned as a cross-sectional investigation. That is, in its major aspect a large sample of the adult population was studied at one point in time, with highly selected information about each subject gathered retrospectively along the life-history axis applied in clinical psychiatry.

In such a study, a further issue for decision is this: What factors of a sociocultural nature should be tested for their relationship to mental health? The interpersonal environment, as a concept applied to a metropolitan population in particular, refers to a social universe of enormous proportions and complexity. To search this enormity for clues and leads to conditions associated with mental illness can be a sightless groping if conducted in haphazard fashion. The only practical alternative is purposively to select from this universe a few theoretically promising (and technically researchable) landmarks for exploration. Prerequisite for such selection is a taxonomic ordering of potential (and testable) etiological factors to which every individual is exposed in varying ways. The taxonomy applied here is based on several simple, cross-cutting distinctions.

One distinction dichotomizes potential or suspected or test factors into two types, designated the *demographic* and the *component.* A demographic factor is a culturally significant property or condition, differentially manifested by all individuals, that provides a basis for classifying a population into a limited series of social segments or groups. We can view demographic factors as falling into two major divisions, namely, the *biosocial* and the *sociocultural.* Under the biosocial rubric belong groups differentiated by sex, by age—or position in the life cycle—and by marital status—or position relative to family formation during the adult phase of the life cycle.[33]

Under the sociocultural rubric we place groups differentiated (1) by socioeconomic status,[34] (2) by religion, (3) by generation in this country,[35] (4) by ethnic or nationality origin of immigrants and their descendants, including Old American, and (5) by rural-urban origin, i.e., the kind of community in which the individual grew up.

The elementary distinction between the biosocial and sociocultural rubrics aside, an analytically more significant consideration requires that we distinguish between independent and reciprocal types of demographic variables. For present purposes, let us assume that one or more of the demographic factors are found to be related to mental health differences, the Study's *dependent* or *response* variable. Given such a relationship,

for a demographic factor to be considered etiologically *independent*, it must satisfy a pivotal criterion, namely, that it is not open to reciprocating influence from, or choice by, the individual and the psychological processes subsumed under the dependent variable, i.e., his mental health. If a factor fulfills this requirement, then we can be reasonably confident that its relationship to the dependent variable proceeds dynamically in a single direction, i.e., as one possible input contributing to the final output.

Examples of the independent type of demographic factor are age[36] and sex, both of which are beyond any possibility of influence or change by processes of individual choice. Other examples we assumed were (1) ethnic origin, as determined by descent, and (2) generation in this country.[37]

Demographic factors that clearly do not meet the criterion of independence in Midtown's adult population are marital status, socioeconomic standing, religious affiliation, and migration from a rural-urban range of childhood communities. Variations in all four may be self-determined, and as such may well be *consequences* rather than independent antecedents of mental health.

To focus on marital status, by way of example, a further observation is in order. Although this factor may be determined in the first instance by psychological characteristics that belong under the umbrella concept of mental health, among newly adult individuals of *like* mental health, differences in marital status may subsequently have disparate effects on their mental well-being. Given this "circular" or "spiraling" interaction through time, if a relationship is found between marital status and mental health in a single point-of-time study such as this, it would necessarily remain ambiguous in its etiological significance. For purposes of the present study, therefore, we postulate that such demographic factors stand to mental health as *interdependent* or *reciprocal* variables.[38]

It should be emphasized, nevertheless, that a correlation established between a reciprocal factor and mental health may potentially have values in its own right. First, the finding that certain marital status groups, for example, represent high risks of mental illness could have important program-planning implications. Second, the ambiguity of direction in the correlation may provide impetus for bringing together scattered bits of evidence that fall into place, as in a jig-saw puzzle, to partially illuminate the relationship, or at least to suggest more refined hypotheses about its nature.[39] And third, appropriate longitudinal studies would be stimulated to lift the ambiguity by following the spiraling course of the interaction through time.

In this volume, present socioeconomic status and religious identification of adults, like marital status, belong in the category of reciprocal variables. But unlike marital status, there was a simple expedient at hand

to capture these demographic factors in a form that would qualify them as independent variables. This expedient was information secured from our adult subjects that permitted classification of each individual in terms of his *parents'* socioeconomic status and religious identification during his childhood. With rare exceptions, such early conditions were certainly beyond his capacity to select or influence. Therefore, any relationship found between either of these two kinds of demographic *origins* and mental health can be assumed to be unidirectional or independent, rather than mutually interactive or reciprocal.

In all, four demographic factors of the sociocultural type were considered available for testing as independent variables potentially related in a unidirectional manner to adult mental health. These were (1) parental socioeconomic status, (2) generation-in-U.S., (3) ethnic origin, and (4) parental religion. It remains to consider more closely how these factors are dynamically relevant to the crucial childhood stage of individual development.

As a point of departure, it may be noted that clinical psychiatry often assesses members of the patient's family during childhood as potential pathogenic agents, generally in terms of their behavior tendencies and interpersonal patterns. As suggested earlier, however, the family must be seen in the larger setting of the community, itself a heterogeneous social system composed of a variety of cross-cutting sociocultural groups, such as those principally defined by four of our demographic factors.

Families, of course, vary in their positions or affiliations relative to each of these four demographic axes of group segmentation. Associated with different group contexts, we assumed, are variations in intrafamily functioning. These variations, we postulated, may ultimately be seen (1) in behavior patterns culturally enjoined or inhibited, through the definition of normative roles; (2) in bonds among the several kinds of family members; (3) in cohesion as this affects the family's emotional economy, stability, flexibility, and control of behavioral deviation; and (4) in family life styles and social resourcefulness. These may affect the frequency with which families internally generate noxious or crisis situations, as well as their immunity-vulnerability in the face of stressful external conditions.

Sociologists have properly charged that "demographic variables, all too frequently, are used as independent variables in a mechanical way."[40] In our formulation, the independent, sociocultural type of demographic factor is seen as one potential key to intergroup differences in intrafamily dynamics.

A psychiatrist has recently expressed views pointing in this general direction:[41]

> One of the great deficiencies in the epidemiological study of all behavioral disease . . . has been the failure to particularize adequately the position . . . of individuals in the various social systems through which they act. . . . Unless

we can do a better job of defining the individual in relation to the various primary groups to which he belongs, we shall not know how to find and to control pathogenic stress, particularly when it may arise in the social and cultural systems.

From the start of the Midtown Study planning process, the writer viewed the demographic variables of the sociocultural type as multiple location points that help identify the specific network of group alignments held by a family in a heterogeneous and complex community. By isolating the independent demographic alignments of the individual's parents during his formative years, we could take the indispensable first step toward testing for possible links between (1) a variety of childhood family settings and (2) various kinds of outcomes for the mental health of their offspring, now adults engaged in the life of a great metropolis.[42]

In this view, the independent sociocultural type of demographic variable may provide guidelines to family-to-family differences in functioning which, as Clausen has since phrased it, "are internalized [by children] in such a way as to produce differing response tendencies to later situations, different ways of coping with one's environment, different self-conceptions and modes of defense."[43] Or, as Stainbrook has trenchantly added, such family alignments permit us to "comprehend . . . the social and cultural world which is not only around [the individual] but which, to a significant extent, is organized within him."[44]

To recapitulate, the typology of demographic factors here advanced for testing in relation to Midtown's adult subjects of study can be summarily outlined as follows:

Demographic Factor Types

	Independent	*Reciprocal*
Biosocial	1. Age 2. Sex	1. Marital status
Sociocultural	1. Parental SES 2. Generation-in-U.S. 3. Religious origin 4. Ethnic origin	1. Own SES 2. Rural-urban background 3. Own religion

Having outlined the structure and potential significance of the demographic variables, we might recall that earlier in this discussion the latter were paired with those we called *component* variables. Since the distinction was not there defined, we can take as point of departure our observation that the demographic factors allow us to probe for connections between certain *kinds* of childhood families and certain variants of adult mental health. However, assume that such connections *are* discovered. In that case, with the family itself functioning as a complex

social system, we will not know which of the many elements operating in this system specifically differentiate the pathogenic and the eugenic types of family structures.

These specific differentials of experience we designate as component variables, and in Volume II look toward, at least partially, to answer why certain kinds of families are more pathogenic for their children than other kinds.

By way of single concrete example, the element of interparental harmony-discord is a childhood experience we place in the rubric of component factor. Some 160 of such items were covered in the Study as potentially relevant to mental health, more or less evenly divided between experiences during childhood and during recent adult life.

Assuming that correlations would be established between some demographic variables and mental health, we originally hoped that the component factors would perform an explanatory or "bridging" role by showing a correlation on the one hand with the implicated demographic variables and, on the other, with the mental health variable.

For purposes of illustration, suppose demographically defined family type Q1 is found to be low in mental morbidity rate and family type Q3 is found to be high in this rate. Taking our previous example of a component factor, it was our hypothesis that interparental harmony would characterize the former family type and interparental discord the latter. If this should prove to be the case, then we would be able to infer that, among other possible respects, the Q3 family type is pathogenic for its children in the specific sense that it tends to be loaded with interparental conflict.

Given the quantity of data secured by the Midtown Study, three books are necessary for their presentation. The division of content adopted calls for concentrated coverage in this volume of our findings on the demographic variables, both of the independent and the reciprocal types. Data on the component variables are being reserved for the second volume. More intensive exploration of Midtown's ethnic families, along one demographic axis, provides the focus for the closing volume, all three books representing a single monographic report of one multifaceted but coherent research undertaking.

A final point of conceptualization implied in passing warrants more explicit statement. In its mission to treat and prevent mental illness, clinical psychiatry, like general medicine of which it is part, has necessarily fixed its attention and energies upon pathology. Going beyond the clinic into the community at large, social psychiatry encounters the well, the sick, and all grades in between. Accordingly, the Midtown Study directed its attention to mental health both sound and impaired, although the latter called for primary emphasis, as we shall see in the two chapters that follow. By the same token, our search for etiological clues was turned

not only to pathogenic factors deriving from the social environment but also to the eugenic or "contrapathic" factors contributing to mental well-being.

In the scientific and humane tasks to which the mental health problem calls, the several vistas must be steadily kept in sight. In the short view, the current untreated sick must be identified, reached, and helped. In the middle-range view, those representing high risks of *future* illness should have ready access to preventive measures. Finally, in the long view more parents must be helped to fortify a child to take "the slings and arrows of outrageous fortune" as they come, yet pursue and find mature self-fulfillment in the service of his fellows.

SUMMARY

From its inception, the Midtown Study was intended to serve the purposes of both program and basic research. Project planning by a multidisciplinary team was carried out at length, on both the conceptual and the technical levels of design.

Of the several alternative approaches available, the one undertaken in this investigation is that of social psychiatry, representing a recent convergence of medical epidemiology, clinical psychiatry, and the social sciences upon a common borderland of research. This approach advances the general postulate that sociocultural forces hold good or ill potentialities for mental health. It rests, moreover, on a general logic of situation-response evidence and inference derived from medical epidemiology. The relationship of this approach to the biological theories of mental illness was discussed, and the limitations upon the Midtown data were indicated.

The chapter also attempts to specify and classify orders of elements in the sociocultural realm as test factors that are potentially relevant to mental health. With the family unit as the crux, these orders range downward in magnitude from the community social system, at one extreme, to detailed patterns of intrafamily functioning (the component variables) at the other. Intermediate were the demographic variables, which were arranged in a typological schema on several taxonomic criteria.

The demographic variables are the exclusive focus of the present volume and are a first possible step toward isolating the kinds of families that are respectively pathogenic and eugenic for the mental health of their members. In fine, the Midtown Study seeks to bring into its broad purview both mental well-being and mental morbidity and such sociocultural conditions as may be associated with each.

FOOTNOTES

[1] R. Fein, *Economics of Mental Illness,* 1958.

[2] R. H. Felix (with M. Kramer), "Research in Epidemiology of Mental Illness,"

Public Health Repts. (*U.S.*), vol. 67, no. 2, p. 152, February, 1952.

[3] It should be added that the initial, tentative formulations, together with assumptions implicit in our decisions, far from remaining "frozen," at certain points followed an evolutionary course of refinement and elaboration through the years of field work and data analysis. Accordingly, this chapter outlines provisional thinking and assumptions in the first year of operations, as subsequently clarified and systematized by the present author.

[4] Of course, each discipline is in a continuous process of conceptual evolution, and special shorthand words must be adapted or invented to fit the new refinements in thought with greater specificity than is usually possible in the popular lexicon. Hence the professional "language" of each discipline, far from being a deliberately esoteric obfuscation of the obvious (as literary critics tend to insist), instead reflects a pressing need, paralleling that of each handicraft, for specialized tools appropriate to its specialized functions. Although this need is usually conceded to the physical sciences, the same prerequisite in the behavioral sciences is not generally understood.

[5] John Whitehorn and Gregory Zilboorg, "Present Trends in American Psychiatry," *Am. J. Psychiat.*, vol. 13, no. 2, pp. 303–312, 1933.

[6] J. E. Gordon, "The Twentieth Century (1920–)," in C. E. A. Winslow et al., *The History of American Epidemiology,* 1952, p. 120.

[7] J. A. Doull, "The Bacteriological Era (1876–1920)," in Winslow, *op. cit.*, p. 76.

[8] Gordon, *op. cit.*, p. 115.

[9] Doull, *op. cit.*, p. 108.

[10] Gordon, *op. cit.*, pp. 124–125.

[11] F. C. Redlich, "The Influence of Environment on Mental Health," *Bull. N. Y. Acad. Med.*, vol. 30, no. 8, p. 614, August, 1954.

[12] Cf. H. W. Dunham, "The Field of Social Psychiatry," *Am. Sociol. Rev.*, vol. 13, no. 2, pp. 183–197, April, 1948; T. D. Eliot, "Interactions of Psychiatric and Social Theory Prior to 1940," in A. M. Rose (ed.), *Mental Health and Mental Disorder,* 1955, pp. 18–41; C. Kluckhohn, "The Influence of Psychiatry on Anthropology in America during the Past One Hundred Years," in J. K. Hall et al. (eds.), *One Hundred Years of American Psychiatry,* 1944, pp. 489–618.

[13] See A. H. Leighton's "Introduction," in A. H. Leighton (ed.), *The Collected Papers of Adolf Meyer,* 1952, vol. IV.

[14] *The Social Responsibility of Psychiatry: A Statement of Orientation,* report no. 13, July, 1957.

[15] A. H. Leighton, J. A. Clausen, and R. N. Wilson (eds.), *Explorations in Social Psychiatry,* 1957.

[16] *Basic Research: A National Resource,* report of the National Science Foundation, 1957. See the statement emphasizing the "importance of social factors in mental health" as a necessary focus for basic research.

[17] Hereafter, the two-word phrase "mental health" is used only in this specific sense of differences along the entire range from "well" or "sound" to "seriously sick." Full specifications of the concept, in operational terms, will be presented in Chapters 4 and 8 and Appendix F.

[18] Franz Alexander, "Psychoanalysis in Western Culture," *Am. J. Psychiat.*, vol. 112, no. 9, p. 699, March, 1956.

[19] Thomas Francis, Jr., "The Teaching of Epidemiology," *J. Med. Educ.*, vol. 29, no. 10, p. 622, October, 1957.

[20] Jack R. Ewalt, "A Case for the Community Self Survey," *Public Health Repts.* (*U.S.*), vol. 72, no. 7, p. 622, July, 1957.

[21] For parallels between meteorological and human causation, see Hans Reichenbach, "Probability Methods in Social Science," in D. Lerner and H. Lasswell (eds.), *The Policy Sciences,* 1951, pp. 121–128.

[22] Historically, the factors in the etiological complex of a given disease are often separately isolated and identified, each, in many cases, after years of exploration by a host of investigators. Even so, for few diseases can it be definitively said that most of the contributing factors have been moved from the rubric of *suspected* to the status of *established.*

[23] T. R. Dawber, G. F. Meadows, and F. E. Moore, Jr., "Epidemiological Approaches to Heart Disease: The Framingham Study," *Am. J. Public Health,* vol. 41, no. 3, p. 280, March, 1951.

[24] Note that a quantitative, actuarial criterion of risk, namely differences in the occurrence of a disease within whole populations, is the decisive clue tracked in the detective hunt to expose it. Given that "the statistical approach is essentially alien to the psychiatrist's thinking" (Redlich, *op. cit.,* p. 613), some clinicians tend to quote Adolf Meyer to the effect that "statistics do not explain the individual case." They may have overlooked the fact that Meyer directly followed this observation with the unanswerable question "Why should they?" (*The Collected Papers of Adolf Meyer,* vol. IV, p. 393). The point implied is that disease rates, operationally speaking, are properties of *groups,* not of any given individual, and that potentially they can lead us to endemic conditions in their populations otherwise hidden to the eye.

[25] The remaining unknowns of course may call for further research of different kinds. Etiological "boxing in" of a disease, like all science, proceeds by the pyramiding of progressive refinements and enlargements of knowledge, method, and theory.

[26] E. L. Wynder, I. J. Bross, and E. Day, "Epidemiological Approach to the Etiology of Cancer of the Larynx," *J. Am. Med. Assoc.,* vol. 160, no. 16, p. 1384, Apr. 21, 1956.

[27] J. E. Gordon, E. O'Rourke, S. L. W. Richardson, Jr., and E. Lindemann, "The Biological and Social Sciences in an Epidemiology of Mental Disorders," *Am. J. Med. Sci.,* vol. 223, p. 319, March, 1952.

[28] The term *mental* in itself usually refers to the cognitive processes. On the other hand, with the sanction of professional usage the phrase *mental health* is accepted as denoting the states of affective-cognitive-interpersonal functioning. It is in this broad, conventional sense that the phrase is being used in this monograph.

[29] Cf. S. S. Kety, "Biochemical Theories of Schizophrenia," *Science,* vol. 129, nos. 3362 and 3363, pp. 1528–1532 and 1590–1596, June 5 and 12, 1959.

[30] With specific reference to the psychosomatic disorders Henry H. W. Miles has observed that "the problems of assessing, evaluating and measuring the genetic and constitutional factors are among the most basic in all medicine and their solution will be a job for future generations of investigators." In P. Hoch and J. Zubin (eds.), *Current Problems in Psychiatric Diagnosis,* 1953, p. 268.

[31] A. Anastasi, "Heredity, Environment and the Question 'How?'" *Psychol. Rev.,* vol. 65, no. 4, pp. 197–208, 1958.

[32] Marie Jahoda has recently commented on this point: "What research and experiment can do is certainly not to solve the problem of mental health and disease. Biological, cultural and situational factors are inextricably interwoven in every human being. For scientific purposes each of these factors has to be singled out for scrutiny, and the result will inevitably be answers to isolated questions, which must be treated with caution when considering the complex of factors which affect the functioning of the whole personality. Provided this is borne in mind, however, such research can be expected to contribute increasingly to a better understanding of mental health problems." In "Environment and Mental Health," *Intern. Social Sci. J.,* vol. 2, no. 1, p. 23, 1959.

[33] Racially differentiated groups presumably also belong in the biosocial category. However, the Midtown population, being racially homogeneous (99% white), does not offer a test of the racial factor.

[34] Specifications of this factor will be found in Chapter 11 of this volume.

[35] This factor encompasses as its groups: immigrants, or first generation; children of immigrants as the second generation; grandchildren of immigrants as the third generation, etc.

[36] It should be added that age is an independent variable in a sense different from the other demographic factors, in that one's present age level is not strictly speaking antecedent to his current mental health. Nevertheless, by the certainty that chronological age level (if not reported years) is beyond individual choice or influence, we can consider that it qualifies under this criterion of independence.

[37] The sole apparent exception is confined to immigrants who came to the United

States of their own volition, i.e., for the most part as adults, rather than as children brought by parents.

[38] The distinction here drawn between independent and reciprocal variables approximates but does not completely parallel the distinction made between "exogenous" and "endogenous" variables by K. Arrow, "Mathematical Models in the Social Sciences," in Lerner and Lasswell, *op. cit.*, p. 151, and between *ambient* and *membership* variables suggested by W. G. Cochran et al., *Statistical Problems of the Kinsey Report on Sexual Behavior*, 1954, p. 296. The former "describes aspects of the surroundings or background of the subject over which the subject has had little or no choice," the latter "referring to a variable where subject's choice is very important."

[39] Cf. E. McCaffery and J. Downing, "The Usefulness of Ecological Relationships in Mental Disease Epidemiology," *Am. J. Psychiat.*, vol. 113, no. 12, p. 1065, June, 1957.

[40] J. B. Lansing and L. Kish, "Family Life Cycle as an Independent Variable," *Am. Sociological Rev.*, vol. 22, no. 5, p. 512, October, 1957.

[41] E. Stainbrook, "Research on the Epidemiology by Psychosomatic Disease," in C. H. Branch et al. (eds.), *The Epidemiology of Mental Health*, University of Utah, Salt Lake City, 1955, p. 47. (Mimeographed.)

[42] Often emphasized as limitations of single point-of-time, or "synchronic," studies is that (1) they can only provide correlations between concurrent variables, and (2) if correlations emerge, they provide no firm basis for discriminating antecedent and consequence. By concentrating primarily on demographic factors characterizing one's childhood family and their linkages to adult mental health, we have in effect converted the Midtown investigation from a synchronic kind of study into one that is at least partially of the general longitudinal-retrospective type. Obviously if a relationship is established between an encompassing characteristic of one's childhood family and his current mental health, there is presumptive ground for inferring the direction of influence from the temporal sequence.

[43] J. A. Clausen, *Sociology and the Field of Mental Health*, 1956, p. 28.

[44] Stainbrook, *op. cit.*, p. 59.

CHAPTER 3 *Study Methods: Design*

Leo Srole

Setting his goals and conceptual guidelines the investigator narrows the ground to be explored and fixes general bearings for his course. In a multidisciplinary study this is likely to entail a complex and painful process of syncretism. Even so, it is hardly more than a brief prelude to the prolonged labors of hammering out the over-all research design and procedural apparatus—field strategies, tactics, and instrumental equipment—in the great number of fine details necessary to the Study's mission.

The specifics of this "tooling-up" process are of little interest to the general reader. On the other hand they are of critical relevance to the expert who must gauge the degree to which the Study's findings can be generalized and judge the "grains of salt" dosage necessitated by limitations in its methods. Hence, an account of the Study's technical apparatus cannot responsibly be withheld from the published record, although it is offered with a "rough going" forecast to the general reader, and a reminder that it is briefly outlined in the chapter's concluding section.

Given the weight of accumulated technical details, the reporting scientist is inevitably driven to condense such an account—sometimes, unfortunately, to a point of extreme capsulation. We are pressed for such a summary exposition here. However, in this account we shall pause to note points of significant conflict, where planning of Study methods encountered dilemmas of choice between disparate alternatives or no-choice decisions forced by such facts of life as limited resources, refractory field realities, and committed study goals.

Without the tempering awareness of these behind-the-scenes problems, the student may regard certain research procedures as unwarranted, or at least eccentric, departures from technical canon in his field.[1] This reaction can be especially elicited by an investigation that is multidisciplinary in scope and audience and eclectic in method by the sheer demands of its objectives.

In this light the present chapter and the one to follow have been prepared. Compact in form, they fall far short of providing a full bill of technical particulars.[2] Nonetheless, they go beyond usual practice by reporting the Study's research design in its main features as these took form in the drafting process.

Certain general issues pervaded the "tooling" phase. One we might briefly discuss here centered on the degree of precision we could expect from our research instruments. The issue is rooted in certain study variables which are not of the either-or type characterized, as in the sex factor, by sharply differentiated classes. Rather, they are of the continuous type, in which variations shade into each other in unbroken array, as in the chromatic spectrum. Some of these, like age, sibling order, and family income, can be expressed in numerical units that permit arbitrary but reasonably accurate discrimination of classes.[3]

For many continuum variables, on the other hand, numerically expressed classification is not yet achievable. Such classification, however crude, is possible now for performance on the IQ test but not for mental health, to offer one relevant illustration.[4] Where this is not possible, discrimination of classes is beset with difficulties of isolating and standardizing operational criteria for consistent and objective definition of such classes. Such definition is what we mean by the terms *precise* and *accurate*. In general, numerically phrased classification is more characteristic of the physical disciplines than of the behavioral sciences, but is not intrinsically peculiar to the former. Evolution in both genera of sciences has been marked by advances in this mode of classification as their bodies of knowledge and technology have expanded.

Our own outlook on this matter, from a vantage point on the new ground of social psychiatry, paralleled that of a contemporary group of investigators working on the epidemiology of cardiovascular disease: "In a state of ignorance, we are willing to accept data with many qualifications. . . . In our field we have so little exact data about most problems that relatively crude approximations are still in order." [5]

Similarly, for the Midtown Study we must disclaim that our available base of knowledge and working tools permit anything more than broad, rough, or crude forms of classification in certain key study variables.[6] On this plane also we can qualify only as an exploratory, rather than as a definitive, investigation.

A second side of the problem raised by nonmetric factors derives from the nature of the analysis to be performed on the data secured. One alternative is statistical analysis, which for certain purposes entails two fundamental kinds of determinations: (1) the scatter of the study population among classes of each investigated variable, and (2) the correlation between distributions on separate variables. Only by these means is the

way opened to systematic, standardized testing of the network of interrelationships among qualitative variables.

The other alternative is to forgo statistical analysis in favor of a purely descriptive mode of ordering and reporting the phenomena studied. This is appropriate for certain purposes where interest in correlations among variables is not germane or must rely, at least temporarily, on the investigator's impression of the interlacings among the factors.

In general, the second alternative is indicated when the focus of investigation is a limited number of cases, whereas statistical analysis is required to discern trends and their interconnections within a large population of cases—as in the instance of the Midtown Study.

Working with roughly categorized nonmetric variables, however, the researcher may be lured into the use of elaborate statistical measures—often on the assumption that their algebraic elegance will compensate for looseness in classification of the study factors. Taking the contrary view, we hold that as a rule such variables do not warrant the application of more than elementary quantification techniques.[7] Even more important, such elementary techniques keep the analysis fixed on the distribution data. They thereby offer a more sensitive picture of a complex relationship than do advanced statistical measures that can conceal more of significance than they reveal.[8] This position between the extremes of purely descriptive exposition and high-order statistical computation will be manifest in all chapters that follow Chapter 7. It is emphasized, in short, that we operate in a field which can muster few claims to the status of exact science.

Responsible for the data reported in this monograph were three research programs or operations that were radically different in their implementing procedures and in their calls upon team resources and energies. The largest of these by far, and the keystone of the entire Study, was the Home Interview Survey. Playing secondary, supporting roles were the Treatment Census and Community Sociography operations, to which we turn first for brief accounts.

THE COMMUNITY SOCIOGRAPHY OPERATION

An investigation focused upon Midtown can, in a special sense, be likened to an intensive case study. Here a community, rather than an individual, is the case.

However, if it is to be understood in its mental health aspects, this subject must first be grasped in its salient underlying characteristics as a social entity. In other words, we must get to know it intimately as a particular kind of population (1) having many historically differentiated group and subgroup segments, (2) residing in a highly specialized physical locale, (3) interacting, to a certain extent, in its own complicated

network of institutions, (4) operating in the grooves of an established way of life, and (5) enveloped by its own pervading sociopsychological climate.

In an immediate sense the effort here must be to portray Midtown to the reader as it strikes the professional, systematic eye of the sociological observer. We refer to this as the *sociographic* approach. This purely descriptive purpose, however, is also a means to a larger end, namely, placement of Midtown in the taxonomy of American communities—on criteria more weighty than surface appearances. Only when this is done can we perhaps judge what Midtown represents as a community entity and thereby determine to what population universe, if any, the mental health findings of this study can be generalized.

The gathering of data for the Sociography operation reported in later chapters was entirely carried out by research aides, sociology students, and a cadre of experienced community volunteers[9] under the direction of the present writer. As responsibilities to other research operations permitted, we adapted two social science traditions of community study. The first is to be found in demographic and ecological investigations conducted for the most part in America's largest cities. These projects extract their data principally from documentary sources in Federal, state, and municipal government agencies.[10]

The second tradition rests on sociocultural studies of relatively *small* communities, with data collected at first hand by extensive participant-observation and interviews with informed residents.[11] The size of our community, as well as the higher-priority claims of our other two field operations, forced us to compromise with this research model. More specifically, we greatly reduced the usual scope of direct and informal participation in community circles and instead drew testimony from two special sources. One source was tapped in the extensive published works of gifted and articulate observer-commentators on the Manhattan scene, some by writers for the incomparable local press.[12] Many of these were long-time Midtown residents. The other source was a large random sample of Midtown adults who were queried on lines relevant to both our Sociography and Home Survey operations. Compared to other studies of this particular kind, therefore, our sociographic data were necessarily more selective than comprehensive and more extensive than intensive.

The mosaic of Midtown assembled from the fact-gathering of our Sociography program is sketched in Chapters 5 to 7.

THE TREATMENT CENSUS OPERATION

The Home Interview Survey, presently to be discussed, could not cover Midtown residents who were in psychiatric hospitals. And we assumed that it would reach too few residents in out-patient psychotherapy to

allow credible analysis. For reasons to be developed in later chapters, both types of patients were germane, not to our search for clues to sociocultural etiologies, but rather to our concern with the human traffic moving through the psychiatric facilities and its practical implications for social policy.

To serve this purpose, the specific mission of the Treatment Census was to enumerate Midtown residents who were patients in the four standard kinds of psychiatric facilities,[13] namely:

1. Publicly supported mental hospitals in New York State—municipal, state, and Federal (i.e., Veterans Administration)
2. Licensed private mental hospitals in New York and adjoining states and major private institutions in more distant states
3. Licensed out-patient clinics in Manhattan—private, and those supported by municipal, state, or Federal funds
4. Psychiatrists and clinical psychologists in private office practice within Manhattan

To Mrs. Frieda Taran and Miss Margaret Bailey, the team's psychiatric social workers, were assigned the manifold responsibilities[14] of carrying out this operation. Sought from the files of the many treatment services covered were data on all bona fide Midtown residents[15] who were being carried on the records of these facilities as "open case" patients, including hospital patients placed in convalescent care status.

By such means the frequency or rate of *treated* mental illness can be determined relative to the Midtown population as a whole and to its various separate demographic groups. However, two standard patient rate yardsticks are available, and their selection depends in part on the time span to be used. One yardstick requires a count of all patients who *enter* treatment over an extended period, usually a year, and disregards people in treatment during that period who became patients *prior* to its opening date. This is referred to as the *incidence rate.*

The other yardstick requires a count of all patients who are open cases at a specific point of time, usually on one particular day, and disregards the length of time since they entered treatment. This is referred to as the *prevalence rate* and expresses the proportion of a population in treatment at any one time.

A spirited controversy between partisans of the two yardsticks livens the epidemiological literature.[16] Without entering into the limitations specific to each measure or common to the two, we can indicate that our Treatment Census operation applied *both* yardsticks. Its "prevalence day" was *prospectively* fixed for May 1, 1953. It "incidence year" was *prospectively* fixed for May 2, 1953, through May 1, 1954. Furthermore, for patients of the publicly supported hospitals, the incidence reach was extended *retrospectively* to cover patients previously admitted during the period from May 1, 1948, through April 31, 1953.

Subsequently, when prevalence and incidence data were put through preliminary analysis, several conclusions emerged: (1) The prevalence yardstick not only was more pertinent to our over-all research design, but for our purposes was beset with fewer questionable assumptions than was the alternative measure; and (2) while both yardsticks were subject to errors of underreporting, the incidence rate seemed to be beset by the larger margin of such error.[17] With the incidence data revealed to be questionable, if not misleading, we see their presentation in the volume as serving no purpose beyond supporting the hindsight view that this aspect of the operation had been unnecessary.[18]

It should be added, finally, that our plan for using the patients' prevalence data also changed considerably during the analysis phase of the Study.[19] Under the influence of insights from evidence gleaned by the other research operations, the Treatment Census prevalence findings are accorded a relatively limited place in the monograph proper, and then only as they can be woven into the more comprehensive scope of the Home Interview Survey. The latter can now be unveiled in its inclusive design.

THE HOME INTERVIEW SURVEY

The Survey's Mission

The primary goal of the Midtown Study was to test the general hypothesis that biosocial and sociocultural factors leave imprints on mental health which are discernible when viewed from the panoramic perspectives provided by a large population. One kind of evidence suggesting such imprints takes the form of intergroup differences in the frequency of mental morbidity. It was our literal-minded position (1) that the Treatment Census operation could strictly tell us only what it counted, namely, the frequency of *treated* mental disorder, (2) that the latter had to be distinguished from *over-all* or total frequency of such illness among nonpatients as well as patients—just as the visible portion of an iceberg must be viewed as only a fraction of its total mass, and (3) that there was no evidence available to indicate that *treated* frequency rates and *over-all* frequency rates are related in a consistent fashion which would allow the former to be accepted as an *indirect* but reliable indicator of the latter.

Since an adequate test of the Study's central hypothesis demanded *direct* evidence on the *over-all* occurrence of mental illness, research of a radically different kind was clearly required—research that cuts away from dependence on institutional records and systematically moves out into the open community for face-to-face assessments of its residents and their individual differences in mental health. This extremely difficult mission was implemented in the Study's largest research operation by far,

and one of such intricacy as to stretch available methods to rather far limits.

The Crucial Decision

The goal of the Home Interview Survey to study the mental health of Midtown residents through direct observation could of course be accomplished only with a sample of its population.

The question of the size of the sample to be encompassed was the obverse face of another question: By what method of mental health assessment shall these people be studied?

The dilemma in effect turned on which question had claim to higher priority in terms of advancing the Study's main goal. On the one hand, if it were demanded that the methods of study should above all else follow the model of intensive clinical examination and diagnosis, then realities would operate to keep the sample small. On the other hand, if the Study's objectives demanded that the sample be large, then realities would compel the adoption of research methods which departed considerably from the intensity of the clinical model.

Given his background in clinical psychiatry, Rennie originally leaned to the first alternative, as was manifest in his initial proposal for intensive examination of a random sample numbering approximately 100 Midtown households. In team discussion of this plan it was pointed out that if the survey's goal was solely to compare *over-all* mental morbidity in Midtown as a unit with that in other communities as units, then the sample size indicated could conceivably (but not confidently) be an absolute minimum for the purpose. However, if the Study's objective went beyond this narrow analytical range into group-to-group comparisons of Midtown's cross-cutting demographic segments, then the suggested sample size would be altogether inadequate. Specifically, to have some of the many subgroups large enough for elementary statistical treatment would require a study sample of 1,500 to 1,600 individuals as an irreducible minimum.

Here came directly into play our view of the special significance of the demographic variables discussed in the preceding chapter. In this light, it was the unanimous decision of Rennie and his research associates that the large sample be the chosen alternative. From this decision followed many inexorable consequences, as we shall see presently.

Sample Design and Participation

Necessary to the selection of a sample are specifications, as precise as possible, of the population universe to be covered. The major specification for inclusion in the Midtown universe was that the individual be a resident for whom a Midtown dwelling is both his primary "home base" and the place he now actually occupies:

1. This included, of course, people in residential hotels and residence clubs but excluded those in transient hotels and clubs.

2. It included living-in staff members of Midtown institutions but excluded the patients and charges in those institutions.

3. It included non-kin members of households, like boarders and living-in servants, but excluded members of a family who, during the period of the survey's interviewing program, were away on extended or indefinite leave, e.g., occupied in military service, domiciled at college, engaged in foreign travel or distant work assignment, or confined in institutions.

4. It also excluded people who had their home base elsewhere, usually out of New York City, but maintained a year-round Midtown dwelling for use on a sporadic or part-time basis. These were designated *secondary residents.*

Requirements of intergroup analysis may dictate a paring down of the universe to be investigated in order to increase sample homogeneity. This reduces the number of subgroups that contend for representation in a sample that is uncomfortably large in administrative respects but uncomfortably small for the investigator's analytical purposes.

On a number of grounds, we scaled the survey's universe down along the axis of age differences. In one direction we decided to confine the survey to Midtowners beyond the formative, relatively protected years of childhood and at least initially launched in the swim of mature life with its various cross currents and undertows. At the other extreme, we decided to exclude adults in the declining years of life, a period when aging and its organic concomitants can complicate the mental health picture and obscure its sociocultural traces. By these boundary definitions the population universe to be sampled was narrowed to people in the prime-of-life stage spanning the ages of 20 through 59.[20] According to the United States census of 1950, the Midtown population in this age range numbered approximately 110,000 individuals.

Out of this host of people, leading largely unexceptional daily lives from the anchoring base of their Midtown dwellings, we had to find subjects for man-to-man study. There are of course a variety of possible methods for securing such subjects. All methods seeking to draw from special categories in the population that are self-defined by reason of the voluntary nature of their actions, for example members of an organization, clients of a social service, patients of a medical institution, subscribers in the telephone directory, or volunteers responding to an appeal for study subjects, will almost certainly produce an unbalanced or biased sample that is unrepresentative of the far more numerous individuals who do not take such actions. This is known as a self-selected or *subjective* type of sample.[21]

At the opposite extreme are the methods of *objective* sampling, de-

veloped principally by the U.S. Census Bureau. These methods permit no self-selection by the subject and, equally important, no option in selection to the investigator with his unwitting potential for biased screening of subjects.

In one of its several variants objective sampling proceeds in essence as if it systematically assigned to every individual in the population universe one in a consecutive series of numbers. All these numbers are then given the same known chance of being selected in a process designated as *systematic drawing from a random start.* In a drawing from these numbers chance alone determines which individuals are chosen. Hence this is also referred to as *probability sampling.* Even the investigator's part in this determination is solely one of following rigorously defined rules to bring chance into play while ensuring that he himself does not intrude in this operation of chance. By mathematically established laws such a sampling plan, if rigorously executed, produces a representative cross section, in miniature, of its population universe—with a *known,* small margin of possible variance, i.e., deviation due to fluctuations inherent in the play of chance.[22]

As applied to a population like Midtown's, the details in the design of probability sampling are highly technical. Suffice it to record that a three-stage area sampling type of design[23] was used in the Home Interview Survey. The stages were as follows: (1) From all city blocks in the Midtown area was first chosen a systematic sample of blocks; (2) from the latter blocks was next chosen a systematic sample of dwellings; and (3) from age-eligible occupants of the latter dwellings finally was chosen a systematic sample of adults. Each objectively selected and specifically identified individual was next assigned to an interviewer, who was barred from accepting any substitute source of information. We would add that by such methods 1,911 Midtowners in the 20 to 59 age range were selected from the same number of dwellings, representing a sampling ratio of 17 per 1,000 individuals in the defined population universe.

Ideally, of course, every individual so chosen should participate in the study. Actually this ideal is never fulfilled, because some individuals are impossible to contact during the study period and others who *are* reached exercise their right to decline participation. Of course, if the nonparticipants are relatively few in number, their absence can have no significant effect on the representative character of the study findings. On the other hand, if the nonparticipants are many, then the investigator must acknowledge that the representative integrity of his sample may have been compromised.

Acting in a form of negative self-selection (i.e., self-exclusion), the nonparticipants may well differ from the participants in various ways crucial to the study's findings, for example, in mental health. But given that the nonparticipants are unstudied, the investigator is in an un-

tenable state of ignorance about the degree and kind of bias left to the studied sample by the defection of nonparticipants in some numbers. This unenviable and by no means rare predicament leaves a study's findings hanging in several senses at "a point of no return."

As we assembled our list of 1,911 sample Midtown dwellings and their occupants, we were acutely aware of this risk: whether they would yield few or many nonparticipants was a contingency which would largely turn on our own management of preliminaries to the interview encounter that was our chosen method of face-to-face study.

This risk was one of several overriding considerations in developing tactics for meeting with our sample people. But before we unfold this phase, perhaps we can jump ahead in chronological sequence to conclude our discussion of the nonparticipation problem. This can be accomplished by reporting the response to our approach for an interview that was made by the 1,911 Midtown adults drafted for our complete sample.

To frame a realistic norm for judging these results, previous sample survey experience is certainly germane. National opinion surveys have found that, on the whole, the larger the community, the higher is the nonparticipation rate.[24] Although these usually manage to hold nationwide nonparticipation to about 10%, in one well-conducted city-wide Detroit study[25] this rate came to 19%. Suggesting perhaps the metropolitan outer limit in this respect is the sample survey of health in the five boroughs of New York City that has reported data reflecting a nonparticipation rate at the 34% level.[26]

Moreover, opinion-survey experience has also shown that, among sections within big cities, the larger the proportion of apartment house dwellings, the greater is sample nonparticipation. As we shall see later in more detail, Midtown is one of the New York areas with greatest density of apartment buildings.

In the light of these experiences we can report that nonparticipation in the complete Midtown sample was kept to an acceptable 13% level,[27] a figure close to the national norm for surveys touching substantive areas considerably less sensitive than mental health. Stated differently, we were able to interview 1,660 individuals, or 87% of all those selected, involving a sampling ratio of 15 per 1,000 persons in the specified population universe[28] drawn from 25 per 1,000 of all Midtown households.

The skeptical reader may well demand assurances more solid than faith that the 1,660 interviewed individuals or *respondents* are indeed representative of the 110,000 adults from whom they were systematically drawn. To meet this "show me" stopper we might inspect these respondents in terms of their age composition. First, we can compare them in this respect with their population universe. The necessary data for the latter have been compiled from publications of the decennial United States census of 1950. However, this census was conducted approximately four

years earlier than the mid-point (March, 1954) of the interviewing program for our Home Survey. Changes had of course occurred in Midtown during this interval,[29] and therefore this sample-to-universe comparison, by itself, is less than completely conclusive.

Accordingly, we will enlarge this comparison by also introducing the age composition of the complete sample of 1,911 individuals.[30] The three sets of age distributions for each sex appear in Table 3-1.

Table 3-1. Age Distributions by Sex in Three Overlapping Populations

Age groups	Interviewed sample (1954) N = 1,660	Complete sample (1954) N = 1,911	Midtown universe (1950) N = 110,000
Males:			
20–29	20.6%	19.4%	21.5%
30–39	23.9	23.4	23.5
40–49	28.7	29.4	28.8
50–59	26.8	27.8	26.2
Total.....	100.0%	100.0%	100.0%
Females:			
20–29	23.0%	22.2%	23.4%
30–39	23.0	22.8	23.2
40–49	27.7	27.8	27.9
50–59	26.3	27.2	25.5
Total.....	100.0%	100.0%	100.0%

With respect to age composition in both sexes, the triangulation (Table 3-1) shows that the interviewed sample[31] achieves practical identity with the complete sample, as does the latter with the population universe. Although still providing less than an ironclad guarantee, which would have required the United States census to be conducted in 1954, these latter two populations, in age and other demographic characteristics,[32] offer warrant for a high degree of confidence that the Midtown sample of 1,660 interviewed adults (respondents) are in fact representative of the population from which they were drawn.[33] On this plane, at least, the survey reaches a known approximation to precision. Without such solidity in the survey's sample foundations, the effects of unavoidable imprecision in its substantive variables might have been grossly magnified.

Methods of Interviewing

Our purpose with each drafted sample adult was to elicit intimate information on certain sectors of his private life: on signs and symptoms relating to both his general and mental health—present and past—on his demographic alignments and social roles, and on central areas of

experience during his preadult and adult years. This is an interview task of extreme delicacy, yet one that had to be projected on a large-sample scale. Clearly, great care had to be exercised in planning this "chips down," climactic phase of the survey operation.

One aspect of the problem revolved around the staging of the interview, and here emerged four principal conflicts between the ideal *should* and the practical *must*. These can now be indicated only summarily:

1. In the interest of strict privacy, the interview should have been conducted at a place other than the respondent's home, preferably in the psychiatric clinic where Study personnel were based. However, it seemed certain that the inconvenience and time required for such travel from home would convert a sizable number of sample draftees into nonparticipants.[34]

Here maximal sample participation and complete privacy of conversation were mutually exclusive alternatives. Ideally we required both. Realistically we could have only one, and in the end the interest of sample integrity prevailed. In compensation, the interviewers made every tactful effort at the home to interrogate the respondent out of earshot of others.[35]

2. To maximize the volume of information secured, several sessions with each respondent would have been desirable. However, previous survey experience warned that under this avowed plan some potential participants would turn into nonparticipants at first approach, and some respondents seen in the first session would not be available for a second. Here maximal individual information and maximal sample participation were mutually exclusive alternatives. In the choice between more data from a biased sample of respondents and fewer data from a representative sample of respondents, the latter was felt to be the transcending interest. Accordingly, it was decided to confine the interview to one session.

3. Ideally, of course, interviewing should have been done by psychiatrists. However, to see so many sample people, at the specific time and place of their convenience, over the short operating span of several months allotted to the interviewing program, was far beyond the capabilities of the limited and overworked supply of psychiatric personnel.[36] Accordingly, the responsibility was delegated to allied professionals who have technical experience in the methods of intimate interrogation. These included psychiatric social workers, clinical psychologists, social caseworkers, and social scientists.

4. Ideally, the interview should have been conducted along the lines of what we might call the open style of interrogation, which allows the interviewer complete freedom to decide the substance, sequence, and wording of questions to be asked in each case. Two considerations argued instead for a structured line of personal inquiry in which the interviewer follows a carefully prepared and standardized schedule of questions;

these considerations arose in spite of our awareness that, as Clausen has phrased it, "Psychiatrists tend to have a profound distrust of data secured by questionnaires or by structured interviews." [37]

First, it was in the survey's interest to secure the largest systematic coverage of information that was possible within the tight compass of a single session. And it appeared likely that the sharply focused, preplanned interview can, on the whole, cover more pinpointed information in a strictly limited period of time than could alternative methods.

Second, and even more important, the structured inquiry minimizes idiosyncratic skewing of the respondent data as a result of the varying personal equations and skills of the interviewers, whereas under open-style interviewing this is maximized. In the latter instance, such "interviewer effect" can variously intrude to undermine the reliability and comparability of data obtained from respondent to respondent.[38] Above all, this is a probability in eliciting mental health information.

On the other side of the coin, the obvious risk in the questionnaire-guided inquiry is its capacity to turn into a perfunctory routine. This real danger was directly faced in the construction of the interview instrument itself, in the determination of the kinds of professionals to be invited to apply for the interviewing task, in the careful selection of applicants, and in the planning of the special indoctrination program to which they were exposed. There they were placed under a specific mandate not only to record the respondent's answer to each prepared question and his spontaneous elaborations and asides, but to report observations of his behavior and to probe replies and comments that were either ambiguous or suggestive as possible openings to matters of further significance. We would note a rough procedural parallel between the interviewer's role as just defined and that of the trained administrator of a projective test like the Rorschach. Both start with standardized stimuli, uniformly administered, and both follow responses with the disciplined inquiry or probe technique.

Thus, if the interview as designed was in structure less fluid than a psychotherapy session, it was certainly more freewheeling than the systematic but hasty review of possible symptoms that often characterize medical intake interviews. Testifying in part to the interview's flexibility in the face of the respondent was this fact: Although minimum time for administration of the questionnaire was about seventy-five minutes, actual individual interviewing time ranged from that lower limit to an upper limit beyond four hours, the average for the respondent sample being about two hours. As an exemplar in clinic case-history recording, Rennie was himself agreeably surprised at the "individual richness of information that comes through in the interview protocols."

Questionnaire Development

If one set of planning problems revolved around the staging of the interview, other problems centered on the contents of the questionnaire that would steer the inquiry in a like pattern for all respondents.

As preliminary, however, we might briefly outline the sequence of steps that had to be taken before the questionnaire instrument was finally ready for oral communication to the first Midtown sample respondent.

It is relevant to note that all members of the Midtown Study team during its planning period were professionally experienced in the open mode of interrogation. Unquestionably, this kind of interviewing, when mastered, is a fine personal art but one difficult to codify beyond its general principles. It therefore offers few specifics that can be transferred to the task of designing a long questionnaire as a detailed and complete entity—itself an exacting, specialized art that conceals endless traps and pitfalls for the unwary novice designer.[39]

As it happened, two team members additionally had an aggregate of about twenty years' experience in questionnaire development for sample surveys in a variety of fields, mental and general health included.[40] Designated by Rennie as the Questionnaire Committee, these members were given assignments (1) to comb the literature on all previous relevant instruments for potentially useful mental health "items" (i.e. questions), and (2) to draft the first version of the survey questionnaire in a form consistent with the Study's outlined framework of concepts and hypotheses.

After months of intensive work the committee submitted its first draft of the instrument for critical discussion by the team sitting *in camera*. On the strength of these meetings and consultations with Rennie and Kirkpatrick, the Study psychiatrists in that period, the committee prepared a second version of the questionnaire for further team discussion and consultation. This interactive process was repeated for nine drafts in all, after which the writer, assisted by Langner as newly added team and committee member, composed the tenth and final form of the survey questionnaire.[41]

It is important to add that three of the nine preliminary drafts were subjected to pretests under field conditions. Used as subjects in these tryout interviews were a total of 145 previously unknown adults living in areas adjacent to Midtown, some drawn from the out-patient rosters of a psychiatric clinic. These pretests were of decisive importance in the development of the survey questionnaire. By reviewing the data produced, and evaluating subjects' and interviewers' reactions to the instrument and interview situation, the committee developed a wide variety of refinements that were carried into the structure, content,[42] and administration of the

questionnaire and into the subsequent training program for the staff of professional interviewers.

Questionnaire Content

On the questionnaire as communicated by sensitive, psychologically knowledgeable interviewers depended the survey's entire framework of concepts and hypotheses.[43]

To do its work this information-moving vehicle was equipped with some two hundred questions pointing to the Study's test factors—demographic and component, independent and reciprocal.

During the development of the questionnaire, these factors posed far fewer problems than did the dependent variable, namely, mental health. Therefore, it is to the latter, as the Study's decisive cutting edge, that this section will look exclusively.

It is necessary to clarify first how the detailed mental health signs and symptoms elicited from the respondent were to be summarized, evaluated, and classified for purposes of hypothesis testing. Of two major alternatives open, the most expeditious would have permitted translation of these details into the psychometric form of numerical scores and profiles. The ideal course, on the other hand, would have one or more psychiatrists concentrate on the interview protocol of each respondent in turn for a global judgment of his mental health condition.

In point of fact, this was at no time a real issue. To Rennie the latter course, although raising a variety of knotty problems, was strategically the only alternative that could be defended before the imperatives of the Study's goals.[44] With Rennie as their preceptor and supervisor, Kirkpatrick and Michael were designated to sit in separate psychiatric judgment on the mental health evidence secured from each sample respondent.

It was under the relatively broad latitude of this strategic decision that the Questionnaire Committee, in collaboration with the team psychiatrists, worked to structure the mental health content of the interview instrument.

As finally evolved the brief on each respondent provided each of the two psychiatric judges with information that included the following:

1. The respondent's free-association elaborations and asides, spontaneous or elicited by the interviewer's probes. In many cases, these were voluminous, in other cases sparse. But in either instance, such added comments often proved to be significant in the clinical judgments of the psychiatrists.

2. The observations garnered by the interviewer during the course of several hours of sustained interaction with the respondent. These the interviewer systematically reported in a prepared outline. The latter covered various aspects of the respondent's behavior, including manifestations of ease or tension, affect or mood, appropriateness of replies, apparent level of intelligence, dress and grooming habits, the presence

or absence of muscular tics, stutter or stammer in speech, memory difficulties, and physical deviations or disabilities. This report was descriptive, rather than diagnostic, and was specifically prepared by the interviewer as a communication to the team psychiatrists.

3. Data derived from our Treatment Census files relating to psychiatric care, if any, during the time span covered by this census (namely, six years for mental hospitals and one year for out-patient facilities).

4. Results of a check made of the records of the New York City Social Service Exchange for a history of personal or family problems brought or reported to one or more of the City's many social agencies, including those attached to the civil courts.[45]

Although important in their own right, these four kinds of information were supplementary to the symptom questions put to all respondents during the course of the interview session. Of course, we could cover only a sample of the universe of possible signs and symptoms. Accordingly, it was our effort to include in this sample such symptoms as would demonstrably represent the most salient and *generalized* indicators of mental pathology.[46] As might be expected, the final series of symptoms covered were heterogeneous in substantive character. To simplify description here, the author finds it convenient to group them under a limited number of rubrics.

One heuristic category is based on behavioral evidence of five types. In type I fall the respondent's replies to queries about a history of epilepsy, of "nervous breakdown," or of seeking psychotherapy. This information, together with data from the Treatment Census and Social Service Exchange files, provides evidence suggesting the probability of a recent history of mental pathology.

To type II are assigned the results of reviewing with the respondent a series of 10 gross somatic disorders that, with varying probabilities, are often attributed to a psychogenic basis. These included arthritis-rheumatism, asthma, colitis, diabetes, hay fever, heart condition, high blood pressure, hives or rashes, neuralgia-sciatica, and stomach ulcer.

What we might designate as *psychophysiologic manifestations* of emotional disturbance[47] are placed in type III and were covered in the interview by 24 questionnaire items referring to nervousness, restlessness, dizziness, fainting spells, headaches, back pains, hand tremors, cold sweats, damp hands, feeling hot all over, insomnia, appetite and digestive disturbances, shortness of breath, heart palpitations, neurasthenia, and excessive intake of coffee, food, tobacco, or liquor.

Type IV behavior relates to memory difficulties reflected in the respondent's denial of the questionnaire statement suggesting that his memory "seems to be all right," a point on which the interviewer reported his own independent observation.

The fifth type of behavioral sign emerged from 18 questionnaire items

focused on current interpersonal functioning within the social settings of family, work, and peer groups.[48] Also important on this level were the respondent's elaborations about these settings, extreme deviations in relating himself to the interview situation, and a problem history on the records of the Social Service Exchange.

Of course, psychiatric evaluation of behavioral symptoms required the sounding of forces potentially underlying them. For this purpose, the questionnaire included 30 items relating to seven selected areas or dimensions of intrapsychic functioning, designated anxiety, inadequacy, depression, rigidity, immaturity, withdrawal, and suspiciousness.

To convey how soundings were taken in these areas, we might illustrate with the series of anxiety items. These included such statements of self-characterization as "I am the worrying type" and "I have personal worries that get me down physically" and also a series of specific kinds of worries, e.g., cost of living, marriage, overwork, children, old age, atom bomb, enemies, and personal health.[49]

Supplementing the questionnaire's coverage of these dimensions were the interviewer's observations of the respondent bearing on four of the areas, namely, anxiety, depression, suspiciousness, and withdrawal. In addition, the respondent's spontaneous remarks were often revealing in terms of one or more of the seven intrapsychic dimensions.

In all, 92 structured questions related to behavioral or intrapsychic symptoms of malfunction during recent adulthood. Also included in the instrument, for purposes of developmental perspective, were 28 selected signs of disturbance during childhood, of course reported retrospectively. These referred to the five types of behavioral indicators and to one intrapsychic area, namely, anxiety.

It remains to indicate that a core series of the symptom items, consisting principally of the psychophysiologic manifestations and those tapping the anxiety, depression, and inadequacy dimensions, were drawn from two previous instruments, namely, the experimental version of the Army's Neuropsychiatric Screening Adjunct (NSA)[50] and the Minnesota Multiphasic Personality Inventory (MMPI). These symptom inventories had demonstrated high reliability and validity in discriminating between groups of psychiatric patients and controls. For the Midtown Study, the symptom items selected from these sources were tested in a pilot validation experiment conducted by Weider. Suffice it here to note briefly that it involved two small samples of Manhattan adults, one a criterion group of 139 diagnosed neurotic and remitted psychotic patients, and the other a control group of 72 people judged to be "well" by an examining Study psychiatrist. From this limited test, almost all the NSA and MMPI symptom questions emerged with validity confirmed.

In this modest validation check, as in the Army NSA investigation, the core series of "psychophysiologic manifestations of emotional dis-

turbance," *18 items in all,*[51] when taken *alone* and expressed in the psychometric form of a numerical count, defined a "critical score" of sufficient discriminatory power to identify correctly about 90% of the criterion group of patients.

It should be emphasized that clinical experience, as well as statistical evidence of validity, was a consideration in selecting the larger sample of symptoms covered in the Midtown questionnaire. By application of the validity criterion, selection in part hinged on evidence that the symptom appears far more often among nosologically heterogeneous psychiatric patients than among psychologically heterogeneous nonpatients. Thus, through a statistical form of guilt by association, such a single symptom can serve as a flag warning that a large reservoir of underlying pathologic disturbance may be present at a level usually found in psychiatric patients. In general, the larger the number of such warning signs systematically canvassed, the greater are the probabilities that mental morbidity will not go undetected among those studied. Viewing the symptom items singly, Rennie was originally skeptical about the discrete value of each for mental health assessment. However, with intensive exposure to the pretest interview protocols his views changed decisively. Weighing the 120 structured "signs and symptoms" items, backed in depth by the four types of supplementary information, Rennie regarded the combined body of information as a highly useful springboard for gross psychiatric judgments about the relative mental health status of each Midtown respondent.

Two important qualifications must now be entered on the record. First, it is considered virtually impossible that the Midtown questionnaire, or any other instrument of this type, or for that matter any single-session psychiatric examination, can be 100% accurate in detecting all cases of mental pathology in a community sample.[52] It is not doubted that certain kinds of individuals, for example those in the early stages of alcoholism or drug addiction, can slip the net of warning signals built into the survey questionnaire. Thus, whatever estimated mental morbidity rate emerges from the Midtown data must be considered to be a *minimal* estimate, one that is an understatement by an unknown but hardly large margin.

Second, it must also be emphasized that other researchers implementing the same goals, working with the same respondents, and otherwise employing the same methods might conceivably have chosen a substantially different sample of symptoms for assessment of mental health. Accordingly, the findings emerging from the psychiatrists' evaluation of Midtown respondents are bound to the specific body of symptomatic information collected for the purpose. In this sense, the psychiatrists' classifications of mental health must be strictly considered as in the nature of operational definitions geared to these particular data.

Orientation of Respondents

The qualifications just entered are linked to another basic issue, namely, the orientation of the sample respondent to the interview itself—a matter bearing directly on the quality of his answers to the questions asked him. The psychiatric patient is often in treatment through motivated self-selection, thereby disposing him to accept professional questioning as a necessary part of the sick role and therapeutic process. This disposition is of course lacking when the objectively sampled individual is being questioned, posing for us the most thorny of all problems in managing the interview encounters with the Midtown respondents.

To a certain extent we can agree that "the quality and quantity of information secured probably depend far more upon the competence of the interviewer than upon the respondent." [53] It was on this conviction that we selected and trained our staff of interviewers, and so far as possible, furthermore, assigned them to match the specific ethnic, social class, and age characteristics of the prospective respondent.[54] But we also recognized that the effectiveness of the most competent and culturally congenial interviewer, standing as he initially does in the role of stranger to the respondent, is in large measure dependent upon the terms in which the interview situation is initially framed for and accepted by the respondent.[55]

In this recognition, we were called upon to define the interview situation in terms of a model that is acceptable because it is familiar and also comfortable, or at least nonthreatening. It is clear, for example, that an interview explicitly defined from the start as being focused on mental health could not possibly serve as such a model. Because this would have cast us as netting candidates for a psychiatric tag, it was almost certain to provoke large-scale nonparticipation[56] and to elicit from participants information of dubious value.

The model actually brought into play was composed of a number of elements, each more or less familiar in itself, but combined in a new pattern. This was conveyed in Dr. Rennie's introductory letter of explanation to the sample household and during a subsequent call at the home by a field staff member to arrange an appointment for the interview session itself. In brief, these elements consisted of (1) communication of the institutional image of the Cornell Medical College, (2) identification of the survey as one focused on community health, (3) specification of method as that of a census, generally known to require a call at the home for individual information asked of many people on prescribed lines,[57] and (4) reinforcement of the professional image in the prearrangement of an appointment, and in Dr. Rennie's written assurance that individual information, like all medical data, would be kept confidential and anonymous.

By opening the interview proper with a bloc of questions bearing on general health and somatic symptoms, we expected that the model would be quickly crystallized as conforming to the familiar medical symptoms review,[58] one that generally reinforces the individual's motivation to give all requested information at his best level of accuracy. This, we believe, gave the interview the momentum to carry, without perceptible resistance, into the subsequent more sensitive areas of mental health symptoms. Moreover, by cutting this large symptom series into a number of smaller clusters of items and by interspersing these clusters through the longer blocs of sociocultural background questions, we felt that attention would not be fixed long enough on the sensitive matter to mobilize censoring anxieties or "response sets."

It seems likely not only that the indicated model provided a motivating role for intimate information giving, but further that, by avoidance of sharply focused attention on mental health, two potential tendencies of an opposite character were more or less kept in check. These were (1) censored denial of existing behavioral and emotional symptoms and (2) stimulation to report nonexisting symptoms under the suggestion of the research interest itself—the spurious "no" response set and the spurious "yes" response set, respectively.

We hasten to add that our avoidance of sharp focus on mental health substance does not imply that we neglected to acknowledge the actual nature of the inquiry to sample respondents. Instead, through the interview we sought to convey, explicitly or implicitly, that mental health is a medical concern and in the domain of our research interest. For example, within the interview's opening bloc of questions on specific somatic conditions, we also asked whether the respondent had ever had a nervous breakdown. Another early bloc, reviewing specific kinds of medical specialists previously consulted, included nerve specialist and psychiatrist. More pointedly, a third bloc of questions was introduced by the interviewer with the comment: "The thing that interests us very much in this research is how city life and city conditions affect people's health, physical and emotional."

This is not to claim by any means that the sample respondent in the role defined was raised to the same self-revealing plane as the self-selected psychiatric patient. On the other hand, we shall soon review evidence suggesting that, with rare exceptions, he was lacking in the hostility or negativism of the "reluctant" patient entered in treatment at the instance of others.[59] More positively, the respondent generally conveyed an initial approach of engaged curiosity, tinged in varying degrees with the sense that the research was professionally responsive to the common interest and therefore to his own self-interest. This orientation was by no means unfavorable to the survey's immediate interest in maximizing the reliability of the respondent's information.

Assessment of the Interview Results

No effort was spared in designing and executing the rigorous process of selecting the survey sample. Similarly, no effort was spared in designing and executing the high-stakes program of interviewing the sampled individuals.

The results of the sampling process can be and have been assessed. Comparison of the 1,660 sample respondents on almost every available demographic criterion has shown them to correspond to a remarkable degree with the population they were intended to represent and with the smaller population of 251 nonparticipants.

The results of the interviewing program, in terms of its three separable aspects, namely, (1) form and content of the questionnaire instrument, (2) structuring of the interview model for the respondent, and (3) actual performances of interviewers and respondents, would require assessment against their common objective: procurement of information from the sample respondents that was at a reasonably high level of reliability or accuracy.

Unfortunately, direct and systematic evidence of this particular type would require that a separate investigation be superimposed on our research design, at a cost prohibitively beyond remaining resources. However, we can marshal some indirect, suggestive evidence bearing on this issue:

1. In sample surveys of the opinion-poll type, it is the usual experience that about 1% of the respondents will break off the interview before it is completed.[60] Such opinion-poll interviews are generally about thirty minutes long and relatively shallow in psychological penetration. By comparison, our interview sessions took an average of approximately two hours, far beyond the limits of even the usual medical or psychotherapeutic session. And in subject content it touched on many potentially painful points across the arc of the respondent's life history. We could therefore plausibly expect breakoffs substantially above the 1% level. In fact, our breakoff rate was slightly under 1%, and most of these cases had proceeded far enough into the questionnaire to permit mental health evaluation by the Study psychiatrists.

2. Information about family income is a sensitive personal matter that in opinion polls is often refused by 5 to 10% or more of the respondent sample. In the United States census of 1950, 8% of the Midtown households refused to report family income. Without the Census Bureau's backing of congressional legislation, we could have expected an income refusal rate above the 10% level. The actual rate of such refusal among our sample respondents was 3.5%.

3. In the sensitive area of private religious beliefs ("To what religious

faith do you now belong?") about 0.5% of the respondents withheld an answer. In a 1958 national sample survey of religious affiliation, conducted by the U.S. Census Bureau, this rate was approximately the same as the income refusal rate. Thus, in Midtown it would predictably have been about 8%.

4. Another item that could readily elicit the answer "It's my private affair" was the pair of questions: "Do you drink liquor, beer, or wine?" and, if this was answered affirmatively, "Like a lot of people, do you sometimes drink more than is good for you?" To either or both of these questions, only 13 respondents (0.8% of the sample) stood on their constitutionally sanctioned rights of privacy.

The above bits of evidence in themselves offer no guarantees that respondents who did not terminate the interview or who did not refuse the requested information necessarily answered the questions correctly. But the low breakoff rate and infrequent refusals to answer delicate queries can be plausibly considered as clues reflecting the positive orientation of the sample respondents to the over-all interview situation. That is, it can be assumed that the same factors which kept these rates at very low frequencies also operated to maintain the respondents' motivation to give answers at a relatively high level of accuracy.

Another type of indirect evidence is provided by the interviewer's observations of the respondent during the course of the session on the criteria of apparent interest in the interview and of tension level. Specifically, he was asked to classify the respondent on each criterion at two points of time, namely, at the opening of the session and near the close.

By analyzing the sample for the over-all trend of change in interest and tension, we can make certain inferences. Of course, given the exceptional duration and content of the interview, we could plausibly expect change in the unfavorable, rather than the favorable, direction. To judge from the interviewers' observations, as summarized in Table 3-2, this expectation is not fulfilled.

Instead of the unfavorable change we reasonably could have expected, we note for both criteria a small but definite change in the other direction. Thus, if our definition of the interview situation had the effect of creating a more or less positive initial orientation among previously unmotivated individuals, then the conduct of the interview inferably counteracted the attrition to be expected from its unusual length and substance.

From all the above clues it can be judged likely that the sustained, predominantly positive orientation of respondents to the interview, as basically modeled after the patient role in the medical situation, operated on the whole to elicit information at an adequate, if hardly perfect, level of reliability.

Table 3-2. Interviewers' Observations on 1660 Sample Respondents during the Interview Session

Respondents' interest in the interview		
Interest	At start	Near close
Lacking	7%	4%
Mild	42	35
High	51	61
Total	100%	100%

Respondents' tension level during interview		
Tension level	At start	Near close
Nervous, fidgety	10%	6%
Sporadic nervousness	27	21
Mostly relaxed	63	73
Total	100%	100%

JUDGMENTAL BIAS IN PSYCHIATRIC CLASSIFICATION

It has been a major purpose of this chapter to indicate potential sources of error and bias that the Midtown investigators recognized and attempted to control in drafting their research design. One such source was anticipated at the point of classifying the respondent's mental health from the data record assembled about him. Although the details of the psychiatrists' classification procedures are discussed in Chapters 4, 8, and Appendix F, the methodological concerns of the sociologists about such techniques can briefly be summarized here.

Of course, mental health is a nonmetric, constellational variable and as yet can only be classified by refraction through the lens of the psychiatrist's perceptual and judgmental processes. Such processes are hardly impervious to influences from the judge's particular theoretical preconceptions and leanings, or from his empirical impressions and hunches, or from his personal values and projections. These uncontrolled influences on professional judgments of "fact" are not readily isolated or quarantined. Therefore in investigations involving judgmentally classified variables their intrusion must be assumed and controlled by appropriate measures in the research design.

The effects of this intrusion are maximal when such classification is dependent upon a single judge. Such effects are reduced when several judges perform the operation. For qualitative classification the principle has long been accepted that "two heads are better than one," on the

ground that each tends more or less to balance the errors of the other.[61] This would especially seem to be the case if each judge forms his opinion without knowledge of the other's, and above all if the two differ in professional training, experiences, and theoretical leanings. By Rennie's design both of these conditions applied to the two psychiatrists he chose to evaluate mental health in the Midtown sample.

However, the possibility remained open that *both* psychiatrists unwittingly would operate under certain shared tendencies toward the same kinds of errors. If so, these would be mutually reinforcing, rather than mutually canceling errors, thereby introducing a systematic distortion in the Study findings. This possibility seemed to be magnified by a well-established procedural point in clinic usage.

By way of background, in clinical diagnosis, psychiatrists customarily "operate" on the patient's case history record as a global whole. It was accordingly taken for granted that the Midtown psychiatrists would do likewise with the sample respondent's assembled record. However, the Study's social scientists pointed out that in the transfer of this universal practice from the therapeutic to the research setting a difficulty of some seriousness would be created. Specifically, the Study was attempting to test the relationship of a series of sociocultural factors to mental health. If the two evaluating psychiatrists were to have the entire record for each respondent, their classifications of mental health would be made with full knowledge of the sociocultural information in each case.

It is not suggested that these Midtown psychiatrists were in danger of premature commitment, on theoretical grounds, to the Study's hypotheses linking specific sociocultural variables and mental health. Both were of course physicians medically trained in a perspective that systematically emphasized the biological foundations of human pathologies. However, a risk of shared bias loomed from another, and less obvious, direction. For example, it was entirely possible that in the course of clinical experience *both* psychiatrists had encountered demographic group Z patients principally as psychotics in hospitals and group Y patients mainly as neurotics in ambulatory facilities.

This kind of professional observation that Z patients seen clinically tend to be sicker than Y patients could readily become an adjudicating criterion in the psychiatrist's judgmental processes when he confronted the sample respondents' records. Specifically, a Z-group respondent and a Y respondent symptomatically may both be borderline cases difficult to classify. However, the felt necessity to push them "off the fence" could lead the psychiatrist to fall back on his clinical observations of patients and accordingly place the Z respondent in the less favorable category and the Y respondent in the more favorable.

With this tendency operating as a systematic bias in *both* psychiatrists, the entire group Z sample could emerge as significantly sicker than

the group Y sample. This might happen despite the fact that the same psychiatrists, judging the same respondents "blind," i.e., without benefit of information on their group affiliations, could yield data subsequently showing that Z and Y respondents are not significantly different in mental health composition. That is, the pathognomonic picture in the selected aggregate of known psychiatric patients may be inadvertently projected on the cross-section representatives of the unknown community population, with effects that distort the facts.[62]

On this general rationale, the Study sociologists urged that psychiatric classification of respondents be made blind to the sociocultural data on each sample individual.[63] On their part, the Midtown psychiatrists emphasized that they could not weigh the mental health import of a set of symptoms which were disembodied from the social characteristics that are an integral part of the individual's identity, life history, and fate.

Acknowledging the force of this point, the social scientists countered that, nonetheless, if such information were admitted to the psychiatrists' judgmental process, any findings bearing on the relationships between the independent demographic variables and the so-classified mental health factor, *whatever their nature,* would be left in a completely suspended state of ambiguity. The objective nature of these relationships being the Study's terminus, posed here was the issue of compromising this central goal.

Out of this impasse a procedural formula emerged, somewhat complicated in detail but serving *both* sets of interests. It took the following lines:

1. From each respondent's record a two-part Summary was prepared as the psychiatrist's working document.

2. Into part I was transcribed all symptomatic information (with several important exceptions to be noted below), including items provided by respondent, interviewer, and several documentary sources. Also recorded here were the respondent's age, sex, and marital status. These biosocial demographic data were included on the insistence of the psychiatrists that they had to visualize what manner of human frame went with the symptoms being evaluated.

3. On the basis of part I information alone each psychiatrist-judge, operating independently of the other, placed the respondent in one of seven categories (later telescoped into six), representing a graded scale of manifest symptom formation and inferred "emotional disability," as Rennie phrased it, for performing the roles of adult life. This classification was designated Rating I.

4. Rating I completed, the psychiatrist turned for the first time to part II of the Summary. Transcribed here were the type V evidence of interpersonal functioning (cf. pp. 41–42) and all other items of respondent information that were coopted by the psychiatrists as germane to

their interest in his social history and interpersonal functioning. Included of course were respondent data bearing on the demographic variables (other than age, sex, and marital status) and on the component factors to be reported in the second volume of this monograph.

Also included were a number of information items highly suggestive of mental pathology but withheld from part I because they offered clues of a demographic nature that were capable of contaminating classificatory judgment. One example is a problem history in one or more social agencies, often associated with the lower reaches of the socioeconomic range. Another is a history as a psychiatric out-patient, which is usually associated with other than the lower socioeconomic brackets.

5. With part II of the Interview Summary reviewed in the context of part I, the psychiatrist now had substantially all of the respondent's record of immediate interest to him. In this more comprehensive light, Rating II could be formed by the psychiatrist as his global judgment of the respondent's mental health—framed in terms of the same seven-category gradient scale as he had used in making Rating I.[64]

6. Of course, in reaching Rating II, the psychiatrist was not bound by the particular grade he had assigned to the respondent as Rating I. However, if a change was made, he was required to inscribe the information items in part II of the record that prompted the change. In point of fact, changes in both directions were made for about one-fourth of all respondents, so that the sample's Rating II distribution deviates somewhat from that of the Rating I scatter.

Although cumbersome, these procedures permitted us to assay the possibility that the psychiatrists' knowledge of a given demographic fact, e.g., socioeconomic origin, as presented in the Summary part II document, had contaminated their classifications of respondent mental health. With Rating I as the "before socioeconomic status (SES) knowledge" judgment and Rating II as the "after SES knowledge" judgment, we could compare the distributions of the two ratings on our sample SES-origin categories. If the net changes made in Rating II were similar in direction and magnitude for all sample socioeconomic groups, it could reasonably be assumed that no systematic SES bias had operated as a result of information in the part II document.

On the other hand, if such changes in one socioeconomic group were loaded toward more favorable classifications, and in another group toward the opposite direction, then the possibility of systematic bias could not be dismissed. Means to further check this possibility were at hand in the specific part II evidence cited by each psychiatrist as warranting all changes made between his Rating I and Rating II evaluations.

The latter step proved to be unnecessary. Comparisons of Rating I and II distributions, on each of four independent demographic variables of the sociocultural type, yielded grounds for confidence that in none of

the four had judgmental bias visibly entered to skew the morbidity findings.[65] For purposes of testing the Study's major hypotheses it is possible, on the basis of this experiment, to shelve the Rating I results in favor of the evidence from the more complete and psychiatrically preferred Rating II classification. With age, sex, and marital status data excluded from the above experiment, we cannot check the possibility that knowledge of these facts had a distorting effect on the psychiatrists' judgments of respondent mental health. However, we shall return to the problem in the appropriate data chapters ahead.

With Rating II serving as the definitive classification of mental health in the Home Survey sample, we should indicate finally that it belongs to the species of yardstick called *prevalence.* More specifically, for each respondent it essentially refers to the condition of his mental health as judged operative during the period he was interviewed.

In one-day prevalence studies of psychiatric patients, e.g., the Midtown Treatment Census, the enumeration day is usually the same for all patients. However, interviewing of the Midtown respondents, limited in tempo by the size of the sample, stretched over a period of months. In this sense, the frequency yardstick applied can appropriately be designated as the sequential, one-day type of prevalence measure.

SUMMARY

In planning the Study's technical design we confronted certain general problems. Among them was the degree of classificatory precision that realistically could be expected. Another was the nature of the analysis to be used in testing hypotheses. These were part of a larger series of dilemmas imposed by conflicting technical alternatives.

In effect, we were making a case study of one community. This genre requires not only descriptive delineation of the case in terms of its relevant characteristics, but consideration of its genotypic significance. Data for this purpose were secured by what we have called the Sociography operation, involving methods adapted from community studies indigenous to the social sciences.

The second of the Study's major research operations was the Treatment Census, assigned to determine the size and demographic composition of Midtown's psychiatric patients, both hospitalized and ambulatory. It was undertaken to illuminate the use of psychiatric services as a problem in institutional traffic and followed certain procedures developed in previous studies of patient populations.

The Study's central goals were entrusted to the Home Interview Survey. As its main features (1) a representative sample of 1,660 adults in the 20 to 59 age range was objectively selected; (2) each sample individual was interrogated for two hours, on the average, by a pro-

fessional person trained and experienced in the intimate interviewing role; (3) the interviewer was guided by a questionnaire that was about one year in preparation.

Planning this survey, the Midtown investigators sought throughout to anticipate potential error and bias in the resulting data and to control these at their several sources by appropriate measures in the procedural design. The three major potential sources were (1) a respondent sample unrepresentative of its population universe; (2) on the part of the respondents, an interview situation not conducive in a number of possible respects to information giving at a level of motivation adequate to Study standards and purposes; (3) on the part of the survey psychiatrists in their role of evaluating respondent mental health, observations derived from clinical or other experiences that could systematically bias their classifications and distort the evidence necessary to test the Study's hypotheses.

Direct evidence was secured assuring that potentialities 1 and 3 were successfully kept in check. As to fruition of potentiality 2, direct information could not have been acquired except at massive diversions of the staff's energies and resources. However, indirect data on respondents' orientations to the interview situation point toward adequate, if hardly maximal, motivation for reliability in their self-reporting role.

In the light of all the indicated evidence, direct and indirect, the investigators can offer their considered opinion that the results of the survey's tests, to be reported later in this book, do not significantly misrepresent the facts about Midtown.

It has been a major purpose of the present technical chapter to share with the reader the extensive grounds for this opinion.

FOOTNOTES

[1] The reality of this possibility has been noted by Lemkau: "Epidemiological methods in psychiatry have already contributed much to our understanding. In all probability they will continue to receive the stinging criticism of psychiatrists and others who believe that to compare even two cases is to violate the concept of the complete individuality of man and who contend that the most, if not the only, important researches in this field are intensive studies of individuals or at most, very small groups of individuals. We can agree with them to some extent; it appears to me to be true that most of the hypotheses to be tested by epidemiological methods originate in clinical studies. On the other hand, if we are to reach any justifiable generalizations in our field, we shall certainly be dependent upon some techniques for testing hypotheses against a larger population than a single case. To be sure in the process some truths about individuals will be lost, but by complementing individual studies, these population investigations will give us a better grasp of the factors in human living that can be changed for the betterment of the mental health of all men." In "The Epidemiological Study of Mental Illness and Mental Health," *Am. J. Psychiat.*, vol. 111, no. 11, pp. 801–809, May, 1955.

[2] Such complete specifications would require a volume in their own right. Some of these details are being reserved for parenthetic discussion in the appropriate data chapters. Certain other technical specifications appear in the Appendixes.

[3] In the broad view, measurement is of course one of several modes of scientific classification.

[4] Discussing one among many proferred definitions of mental health, Marie Jahoda comments: "From a purely logical point of view this definition leaves loopholes. . . . Yet for the practical purposes of the mental health professions, for scientific discussion, for research and even for therapy, this type of definition serves its purpose; notwithstanding its generally recognized inadequacy, it provides a starting point from which knowledge can be gathered that may lead to more accurate formulation." In "Environment and Mental Health," *Intern. Social Sci. J.*, vol. 11, no. 1, pp. 15–16, 1959.

[5] F. E. Moore, Jr., "Problems in the Selection of a Universe for the Study of Chronic Illness," *Milbank Mem. Fund Quart.*, vol. 31, no. 3, p. 28, July, 1953.

[6] This will be more fully elaborated in Chaps. 4 and 8.

[7] For a general elaboration of this view see H. C. Selvin, "A Critique of Tests of Significance in Survey Research," *Am. Sociological Rev.*, vol. 22, no. 5, pp. 519–527, October, 1957. With specific reference to statistical tests of significance, Jerome Frank has made the pertinent observation that "statistical measures of significance may be misleading in that a statistically significant finding need not be significant in the non-technical sense of the term." J. D. Frank, "Problems of Controls in Psychotherapy as Exemplified by the Psychotherapy Research Project of the Phipps Clinic," in E. A. Rubinstein and M. B. Parloff (eds.), *Research in Psychotherapy*, 1959, p. 23. On the other hand, Stouffer adds, "Even when no individual pair of percentages is significantly different [by statistical test], a pattern of such differences, most of them in the same direction, may be highly significant." S. Stouffer, *Communism, Conformity and Civil Liberties*, 1955, p. 273. In Chaps. 9 through 16 we shall for the most part be concentrating not on pairs of percentages but on the *direction* of differences across a set of three or more distributions.

[8] David Gold, "Some Preliminary Observations on the Qualitative-Quantitative Distinction in Statistical Analysis," paper read to the American Sociological Society meeting, Seattle, August, 1958.

[9] See Appendix A.

[10] An excellent example is E. Shevky and M. Williams, *Social Areas of Los Angeles*, 1949.

[11] Examples are: Robert Lynd and Helen Lynd, *Middletown*, 1929; J. Dollard, *Caste and Class in a Southern Town*, 1937; W. L. Warner, L. Srole, P. S. Lunt, and J. O. Low, *Yankee City Series*, 1941–1947, vols. I–IV; and J. R. Seeley, R. A. Sim, and E. W. Loosley, *Crestwood Heights*, 1956.

[12] It is apposite to recall that Adolph S. Ochs, publisher of one of these newspapers, commented to the effect that however lurid the treatment of a crime in the tabloid press, "if the *New York Times* publishes it, it's sociology."

[13] These cover the entire psychiatric treatment "waterfront" (exclusive of special institutions for the mentally deficient), but they represent a compromise with Rennie's original hope also to include troubled people in nonpsychiatric but "corrective" organizations and institutions, e.g., certain civil and criminal courts. As is true of other relevant institutions of this type, the enormous administrative complexity of the New York City courts made systematic screening of their records for Midtown residents a burden impossible to assume along with coverage of the complex system of psychiatric facilities.

[14] These included the function of soliciting the cooperation of all of the above treatment units. For extending such help, acknowledgments are here gratefully accorded to Dr. Henry Brill and his staff in the research section of the New York State Department of Mental Hygiene, as also to the private therapists and clinic and hospital administrators in numbers far too large to identify individually here.

It should be noted parenthetically that the cooperation solicited carried assurance from the Study director and the Cornell Medical College department of psychiatry, guaranteeing the complete professional confidentiality of the patient data made available for the scientific purposes of the Midtown Study.

Also assigned to the team social workers were the tasks of transferring data on

hospital patients directly from official files and processing patient reports prepared and submitted by the other kinds of treatment services.

[15] The phrase "bona fide" was defined to exclude people listed as last domiciled at a Midtown address but hospitalized continuously for five or more years.

[16] Since the controversy is a recurrent one and is revived with each new study monograph, it is important that our minority position on the issue be clarified. This technical discussion appears in Appendix C.

[17] Although lacking documentary proof, we believe that Midtown's *incidence* patients reported quarterly by clinics and office therapists were less complete than the patients they reported for our one-day *prevalence* count.

[18] For the benefit of the student, this can be properly identified as the "waste motion" phenomenon that undoubtedly comes to roost in many investigations, but is publicly acknowledged by few.

As to the principle involved in such acknowledgments it has been observed: "It is truly unfortunate that . . . there is not more opportunity for the thoughtful and honest airing of the dilemmas, compromises and problems of carrying out research. . . . Most research is described as if it went off perfectly according to plan. There is little chance to learn from the mistakes of others. . . ." Joan K. Jackson, in a book review, *J. Health Human Behav.*, vol. II, no. 2, p. 161, Summer, 1961.

[19] The statistical analysis was carried out by Thomas S. Langner and his staff under the direction of the author of this chapter.

[20] These particular age cutoff points were selected for the Home Interview Survey to conform with the age classifications of the U.S. Census Bureau. Thereby, it would be possible to check the sample in terms of age composition and related criteria against its population universe as determined by the Census Bureau.

It should be noted, on the other hand, that the Treatment Census operation set no limits on its age coverage.

[21] One consequence of this type of sampling has been noted in the literature on cardiovascular disorders. "Numerous hypotheses have been proposed relating many factors, both host and environmental, to the development of coronary heart disease or hypertension. Controversy exists regarding practically all such hypotheses. A great deal of controversy has been due to the difficulty of obtaining a population free of bias in which to test the hypothesis." T. R. Dawber and W. B. Kannell, "An Epidemiological Study of Heart Disease: The Framingham Study," *Nutrition Rev.*, vol. 16, no. 1, pp. 1–4, January, 1958. See also Cochran et al., *Statistical Problems of the Kinsey Report on Sexual Behavior*, 1954, pp. 55, 262, and 265.

[22] The larger the sample in absolute members, the smaller is the margin of such "random error" deviation or "sampling variance."

[23] M. H. Hansen and P. M. Hauser, "Area Sampling—Some Principles of Sample Design," *Public Opinion Quart.*, vol. 9, no. 3, pp. 183–193, Summer 1945.

[24] Stouffer, *op. cit.*, pp. 242 and 244.

[25] A. Kornhauser, *Detroit As The People See It*, 1952, p. 194.

[26] *Health and Medical Care in New York City*, Committee for the Special Research Project in the Health Insurance Plan of Greater New York, 1957, p. 211.

[27] Of the 1,911 selected individuals, only 2.3% were in the "never contacted" category of nonparticipation, reflecting the survey policy of no specific upper limit to the number of possible return calls to sample dwellings. Another 7.2% were "contacted refusals," many revisited after the initial refusal. The final 3.5% consisted of "contacted miscellany," none refusing to be interviewed, but all being unable (or unwilling) to arrange the necessary appointment during the period of the interviewing program. Cf. H. Sharp and A. Feldt, "Some Factors in a Probability Sample Survey of a Metropolitan Community," *Am. Sociological Rev.*, vol. 24, no. 5, pp. 650–661, October, 1959.

[28] With 1,660 individuals the range of sampling variance can be suggested through this example: If 25% of these individuals were found to have blue eyes, then the probabilities would be very high (95 in 100) that the proportion of blue-eyed people in the population universe stands somewhere between 23 and 27%.

[29] As illustration, the 1950 United States census reported that one particular Mid-

town block was unoccupied. Two years later, it held a towering high-rent apartment development and, by the play of chance, it was drawn into our sample of blocks.

We should add that for Manhattan the decade 1950–1959 marked the greatest demolition and construction boom in its history. In the residential aspect of this boom, low-rent tenements were replaced by privately sponsored luxury apartments. Thus, if Midtown in 1954 was not exactly what it had been in 1950, by 1960, even more patently, it was not what it had been six years earlier.

[30] This was made possible by securing pertinent demographic and other information, through direct or indirect means, on all the sample nonparticipants.

[31] For purpose of convenience, this will hereafter be referred to as *the sample.*

[32] For further comparisons of our interviewed sample and its population universe see Appendix D.

[33] It remains theoretically possible, of course, that sample nonparticipants and interviewed respondents are essentially alike in demographic composition but different in mental health composition. If so, the latter would be a biased sample in this specific respect. To test this possibility, at least partially, we can compare the two groups on frequency of psychiatric histories as independently uncovered by our Treatment Census operation. The latter found that among the interviewed respondents 3.4% appeared on its records as having been a patient of a mental hospital, clinic, or office therapist within certain specific time periods. The corresponding figure for the nonparticipants was 3.2%. Thus, the two groups do not appear to differ with specific respect to institutionally known and reported mental pathology.

[34] Epidemiological studies of community samples that involved free medical examinations in the clinic have actually encountered this problem on a large scale. See T. R. Dawber, F. R. Moore, Jr., and G. V. Mann, "Coronary Heart Disease in the Framingham Study," *Am. J. Public Health,* vol. 47, no. 4, p. 4, April, 1957; and *Chronic Illness in a Large City,* Commission on Chronic Illness, 1957, pp. 208–216.

[35] To judge from interviewers' regular reports on this point in the protocol, close to half of the sessions were held under "ideal" conditions of privacy, another 40% with some brief interruptions—including telephone calls, ringing doorbells, or children demanding attention. The remainder involved small children or a radio operating somewhere in the house as a prolonged distraction. With few exceptions the interviews appear to have been conducted beyond the hearing of another adult.

[36] An additional consideration has been pointed out by Clausen: "Relatively few psychiatrists feel comfortable about examining persons who have not sought help and to whom services are not to be offered." J. Clausen, "The Sociology of Mental Illness," in R. K. Merton et al. (eds.), *Sociology Today,* 1959, p. 493. Pointing to an almost universal gap in the training of psychiatrists, others have traced this discomfort to inexperience both in home treatment and in home visits for case study purposes.

[37] J. Clausen, *Sociology and the Field of Mental Health,* Russell Sage Foundation, 1956, p. 49.

[38] "It is clear that interviewer effect is a fundamental problem faced by all the social sciences which make use of the interview method in the collection of data. . . . Interviewer effects in all these fields have their parallel in the errors of observation and measurement or interpretation found in other sciences. When we note that there are observer differences in reading chest X-ray films or in interpreting the results of laboratory tests of syphilis or in appraising the malnutrition of children from medical examinations . . . or in noting the transit of stars in a telescope, we must acknowledge the fact that interviewing is not uniquely vulnerable." H. Hyman, *Interviewing in Social Research,* 1954, pp. 13 and 14. (See also Hyman's discussions of research on psychiatric interviewing, pp. 9, 94, 121, and 383–384.)

[39] See S. L. Payne, *The Art of Asking Questions,* 1951; M. Jahoda, M. Deutsch, and S. W. Cook, *Research Methods in Social Relations,* 1951, vol. I, pp. 151–208; H. Hyman, "Interviewing as a Scientific Procedure," in D. Lerner and H. D. Laswell (eds.), *The Policy Sciences,* 1951, pp. 203–218; and R. L. Kahn and C. F. Cannell, *The Dynamics of Interviewing,* 1957, pp. 131–165.

[40] These were Arthur Weider, clinical psychologist, and the present writer, with wartime service as military psychologist in AAF rehabilitaton hospitals.

[41] Approximately a year of work intervened between formation of the committee and completion of the final instrument.

[42] It has often been observed that uniform wording of a question may have different meanings for different respondents. Of course, this is less likely to happen if the established rules of questionnaire construction are respected. Above all, the procedure of the field pretesting of a questionnaire has as one of its main purposes the detection and correction of unanticipated difficulties among respondents in understanding or interpreting questions.

[43] See Chap. 2.

[44] "The only present criterion for mental illness, in the last analysis, is the clinical judgment of psychiatrists." E. M. Gruenberg, "The Epidemiology of Mental Disease," *Sci. American*, vol. 190, no. 3, pp. 38–42, March, 1954. It has been relevantly added that such "clinical judgment is a result and expression of a communicated art rather than a mode of relatively precise measurement." Seeley, Sim, and Loosley, *op. cit.*, p. 409.

[45] Experience indicated that such a history would be found in the upper-income groups in too few instances to warrant the high cost required to check the entire sample. Accordingly, only respondents in the lower 60% of the sample's socioeconomic range, approximately, were so checked.

[46] Kubie has defined a similar sampling process in clinical practice: "Good history taking is extremely difficult. . . . You can't take it all. You have to sample, selectively rather than randomly." In a lecture to Payne Whitney Clinic staff, Feb. 14, 1957.

[47] See R. C. Cowden and J. E. Brown, "The Use of a Physical Symptom as a Defense against Psychosis," *J. Abnormal & Social Psychol.*, vol. 53, no. 1, pp. 133–135, July, 1956.

[48] It should be noted that the area of interpersonal and role functioning originally had a somewhat secondary place in the framework of symptoms covered. However, when the team psychiatrists began their trial assessment of the sample interview protocols, this area, although less thoroughly explored than would have been possible, assumed a more central position. Its importance in the psychiatrists' classification of respondent mental health will be more fully discussed in the chapter that follows.

[49] For questionnaires designed by psychiatrists to tap the anxiety area, see G. Saslow, R. Counts, and P. DuBois, "Evaluation of a New Psychiatric Screening Test," *Psychosomat. Med.*, vol. 13, no. 4, pp. 242–253, July, 1951; and H. Basowitz, H. Persky, S. Korchin, and R. Grinker, *Anxiety and Stress*, 1954, p. 31.

[50] See Shirley Star's account in S. A. Stouffer et al., *The American Soldier*, 1949, vol. II, pp. 411–455; vol. IV, pp. 486–567.

[51] In the interview summary form presented in Appendix E, these core symptom items can be identified by their code number as follows: R5–1, R6–1, R6–6, R7–1, R7–6, R8–1, R8–6, R9–1, R9–7,8, R10–6, R17–6, R18–1, R18–5, R19–1, R19–5, R20–5, R45–2, and G9–3, 4. Among those items which did *not* discriminate Weider's particular criterion group (of patients), some were included in the Midtown questionnaire on the strength of the psychiatrists' knowledgeable judgment that they *were* clinically significant nonetheless.

[52] For the closely related field of mental retardation, it has been observed: "Research cannot wait upon the development of diagnostic tools of 100 per cent accuracy in the detection of pathology, particularly of the central nervous system." S. B. Sarason and T. Gladwin, *Psychological and Cultural Problems in Mental Subnormality: A Review of Research*, 1957, p. 9.

[53] T. Caplow, "The Dynamics of Information Interviewing," *Am. J. Sociol.*, vol. 62, no. 2, p. 169, September, 1956.

[54] These three characteristics, among others, were approximately known to us through contact with the household prior to the interview.

[55] "The 'depth' of any item of information depends upon its meaning for the respondent, which, in turn, depends upon how he perceives the relationship between the information and the total social context in which it is given. What is in one social situation a mere 'objective fact'. . . may be a devastating threat in another. . . . Deep information is presumed to be accessible to the interviewer under certain con-

ditions, and his hope for success depends upon his manipulating the respondent's definition of the situation in such a way as to make what would ordinarily be deep information come to the surface. The word 'ordinarily' is important as recognizing the norms regarding what should be communicated to whom under what conditions, as well as how the communication is to be carried out." Raymond L. Gorden, "Dimensions of the Depth Interview," *Am. J. Sociol.*, vol. 62, no. 2, pp. 158–159, September, 1956.

[56] This would likely happen more often among the mentally ill than among the well, in that event seriously biasing the sample of participants.

[57] This also served the important function of keeping the interview situation free of any implication that professional treatment, consultation, or advice would conclude the process. However, if such help was requested by a respondent, the interviewer had instructions to arrange a no-charge consultation session with a Study psychiatrist.

[58] We would note a relevant publication in the series reporting methods and results of the nationwide study of chronic somatic illness and disability being conducted by the National Health Survey as a continuing program of the United States Public Health Service. This publication presents findings from a special investigation to evaluate "the effectiveness and reliability in a [sample] survey of the medical-history-taking procedure." Reported as a central finding was this: "It seemed clear that it would be possible to develop a standardized series of special purpose medical-history-taking questions, and that survey respondents do not hesitate to answer such questions. In fact, people seemed delighted to have the opportunity to talk about their symptoms and illnesses. The answer to the first question under study—namely, would people freely discuss their medical history in a situation in which they had not taken the initiative in seeking medical care—seemed obvious. There were no apparent major barriers to obtaining medical-history data for research purposes. Subsequent interviews sustained this general conclusion." "A Study of Special Purpose Medical History Techniques," *Health Statistics from the U.S. National Health Survey*, ser. D, no. 1, 1960, pp. ii and 4.

[59] S. E. Dean, "Treatment of the Reluctant Client," *Am. Psychologist*, vol. 13, no. 11, pp. 627–630, November, 1958.

[60] Cf. Stouffer, *op. cit.*, p. 241.

[61] R. Taft, "Multiple Methods of Personality Assessment," *Psychological Bull.*, vol. 56, no. 5, p. 349, September, 1959.

[62] For a study tending to confirm this possibility see W. Haase, "Rorschach Diagnosis, Socio-economic Class and Examiner Bias," unpublished doctoral dissertation, New York University, 1956.

[63] To be noted in this connection is a sample survey of the association between periodontal disease and socioeconomic status, conducted by the National Institute of Dental Research. In observance of the "blind" principle, the research dentists examined the teeth of each sample subject while deprived of any information that might offer a clue to his socioeconomic standing. A. L. Russell and P. Ayers, "Periodontal Disease and Socioeconomic Status in Birmingham, Alabama," paper read to American Public Health Association, Oct. 29, 1958.

[64] The psychiatrist next applied two other kinds of classificatory schemes to the respondent's full record. But since these will only be put to the most peripheral use in this volume they need not detain us here.

[65] It is beyond our purview to speculate about the explanations for this result, except to note three obvious possibilities: (1) The two psychiatrists had no preconceptions about the mental health of Midtown's sociocultural groups; (2) they had such preconceptions, but these differed and in effect balanced each other out; (3) they had like preconceptions, but the procedure of citing the evidence justifying their changes in Rating II may have made them aware of such prejudgments in a form leading to restraint in their expression.

CHAPTER 4 *Study Methods: Mental Health Ratings*

Price Kirkpatrick and Stanley T. Michael*

The authors of this chapter are two of the three psychiatrists concerned in the mental health rating. The third was Thomas Rennie, whose untimely death prevented his participation. Our aim is to give, in synoptic fashion, our viewpoint as clinical psychiatrists with reference to the way in which we approached the questionnaire and helped in its design and the manner in which the mental health ratings were carried out, as well as our opinions regarding the kind of meaning and significance which can be attached to the results. More detailed exposition will be found in Appendix F.

As indicated in Chapter 3, the Midtown Study had from its inception the problem of communication between the several disciplines involved. Beyond communication, however, there has also been the problem of orientation; by this we mean that different disciplines tend to view the phenomena of nature differently. Thus, the psychiatrist, as he learns about social theory and the methods of sociology, may still not come to see human behavior altogether in the same terms and with the same flavor and frame of reference as the sociologist. Similarly, the sociologist, even though he may become well versed in psychiatric theory and able to employ its technical language, may still not see people and the things they do in quite the same light as does the clinician. Although there may be sympathetic recognition by each of the other's ideas, there remains a difference in training, experience, and habits of mind. Behind these contrasts there lie others of orientation and of attitude toward the character of the scientific method itself.

Up to a point, it is possible to achieve reconciliation of these divergences. On the other hand, there is something to be said for letting some contrasts in orientation stand as they are. Most of those which we have experienced are certainly not peculiar to the Midtown investigation but are to be found in many other places where research in social psychiatry is attempted. Setting our clinical views down separately from those of

* Director, Kennebec Mental Health Clinic, Waterville, Maine.

the social scientist may have the merit of letting the reader see for himself the areas of congruence and divergence in orientation. The presentation of such limited diversity may enrich the opportunity for advancement of knowledge as well as make more understandable the nature of this study. Certainly, in our working together, the clarification and recognition of some of the issues have been beneficial to us.

QUESTIONNAIRE OR DIRECT EXAMINATION?

In the beginning Rennie gave careful thought to the question whether the Midtown sample should be examined directly by psychiatrists, and a diagnosis made on each individual, or whether the psychiatric assessment should be made indirectly through the medium of a questionnaire-structured interview conducted by related professionals. Despite the obvious advantage of having the psychiatrist talk directly with and observe his subject, the decision was made in favor of the indicated questionnaire-interview. A principal consideration had to do with the problem of ensuring reasonable uniformity of inquiry and diagnostic criteria in an interviewing team that inevitably would have required many psychiatrists.

PREPARING THE QUESTIONNAIRE

Of the two authors of the present chapter, Kirkpatrick joined the Midtown Study at the time the mental health items were being selected for the questionnaire instrument. As assistant to Rennie he helped in a psychiatric review of all the questions which were proposed by other members of the team, as outlined in Chapter 3. The two psychiatrists introduced some forty additional questions, bearing particularly on psychosomatic symptoms, phobic reactions, and mood. Derived from clinical use of a mental status examination (the systematic review of psychological functioning), numbers of questions bearing on the same theme were scattered in different parts of the questionnaire so that the respondent's feelings could be tapped at different times during the course of the interview.[1]

Final decision with regard to the inclusion of each mental health question was made by Rennie. We do not feel it would be proper to attempt to speak for him on the rationale behind all his decisions. Time has passed since that stage, but certain general points can be made with the conviction that these do represent lines of thought in which the clinicians shared.

First it should be noted that the primary basis for the psychiatrists' choice and decision was clinical experience. By this is meant each rater's years of work in internal medicine, his training in psychiatry, and his years of work in the diagnosis and treatment of psychiatric patients.

Knowledge acquired by reading and discussion with colleagues had, of course, a place in this, but it was fused into the general experience; much more in the foreground was the learning derived from interaction with patients.

The process of item selection has been described in Chapter 3. The validated items were reviewed by the clinicians with regard to their appropriateness to the interview situation as a whole and to their usefulness for clinical judgment of morbidity. The clinicians also added items of their own construction derived from their professional experience.

We hoped to include questions in sufficient quantity and of such a range that there would be some information provided regarding the presence or absence of malfunctions which might be of clinical importance. Such data were not regarded as discrete, listable behavioral items, but as patterned complexes of factors in which each perceived item has meaning only in relation to the other items present, and in which the meaning of the whole depends not only on the items present, but on their relationship to each other.

The individual human being was regarded as a functional unit, with adaptation to life's circumstances as an important theme in his existence. The notion of function and malfunction deserves some discussion, and a comparison can be made between psychological and physical functioning. Both in physical and in mental health, there is an extended gradation from health to severe morbidity. But whereas physical illness may be precisely defined by structural and functional impairments related to the body, mental illness involves a particular function which relates the individual to his social environment. Society emphasizes the individual's ability to maintain socially acceptable behavior, to care for himself, and to refrain from interfering with others. Mental health might accordingly be defined as the freedom from psychiatric symptomatology and the optimal functioning of the individual in his social setting. It could hardly be otherwise assessed.

It should be noted further that in psychiatry *function* has a rather specific meaning within the general significance reflected in the preceding paragraph. This can be seen in the distinction commonly made between functional and organic mental disorders. Modern chemistry and biophysics suggest that even though functional disorders do not involve obvious structural damage to the brain or gross toxicity such as can be observed in organic disorders, in one way or another there is an accompanying physiologic disturbance, even if it is only at the molecular level. From a descriptive point of view, however, the functional-organic distinction still has its pragmatic uses. *Organic* is used here in its traditional sense as descriptive of disease representing gross structural or histological change. *Functional* disorder, by contrast, characterizes impairment of activity quite out of proportion to any evident structural

pathology. Such impairment may beset not only observable physical activity but also the feeling state and the thought processes.

Rennie was fully aware that the special preoccupation of the physician is primarily with pathology and secondarily with health, that the medical man is trained and tends almost unthinkingly to describe health in terms of pathology, and that the pathologic, whether physical or mental, has a way of making itself much more obvious than the more pedestrian normal. So that the staff would keep alert to the functional (rather than the malfunctional), in the sense of positive mental health and the strengths of the personality, Rennie chalked relevant criteria on a blackboard by the staff conference table. Although these were not intended as instructions for questionnaire design, they did serve to express the staff psychiatrists' intention that their evaluation of respondent mental health should take into account assets as well as liabilities of the personality.

The first two criteria were "freedoms"—from various gross symptoms and disabling inner tensions; the others were capacities:

1. Ease of social interaction
2. Capacity for pursuit of realistic goals
3. Fulfillment of biological needs, such as child bearing and rearing
4. Satisfying sense of social belonging: sensitivity to the needs of others
5. Feeling of adequacy in social roles (particularly sexual)
6. Optimal balance between independency-dependency, rigidity-plasticity needs
7. Capacity for utilization of essential creativity
8. Capacity to accept deprivations and individual differences
9. Conservative handling of hostilities and aggressions
10. Identification with ethical and moral values
11. Adaptability to stress (homeostasis)
12. Healthy acceptance of self (e.g., body image and ego image)

This outlook regarding positive mental health was kept strongly in the minds of the psychiatrists and came into play during the rating process. Often the evidence for the above criteria appeared in the respondent's spontaneous comments, elaborations, and asides.

These remarks on the functional orientation in terms of which the psychiatrists exerted an influence on the selection of questions for the interview also apply to the judgments used in the rating process, which will be described next. It is evident that these criteria lack precision and have a certain amorphous quality, especially when one tries to set them down in a small space. This arises from the fact that their roots are in clinical work, which is characterized not only by a certain logical frame, but also by intuitive feelings and responses to patterns based on experience with patients.

To put the matter tersely, we used our clinical judgment to the best of

our ability. It would be a mistake, however, to overlook the fact that there remain some aspects of the process which are not altogether in our awareness. In this our activity shares with many other kinds of human judgment; otherwise court procedures and art criticism, as well as medical diagnosis, could be performed by machines.

RATING THE QUESTIONNAIRE

A major problem confronting the Study psychiatrists hinged on classifying the heterogeneous data secured on each individual respondent. It became apparent very soon that we could not make a diagnosis, in the usual sense of the word, on the basis of this material. Symptoms could be listed and complexes of symptoms could be appraised as probable diagnostic categories, but the nature of the data led us more in the direction of some kind of over-all evaluation of mental health functioning. This assessment reflected awareness that differences in functioning seemed to be the more appropriate appraisal to make, and that one could do this quite independently of the various categories of clinical patterns and their implied etiologies. It was as if one were going to rate a population with many different kinds of ill-defined physical disorders; in such a situation he could place each individual somewhere on a linear scale of functional impairment.

Let us repeat, this does not imply that the standard nosological types of mental disorder can be accorded a fixed position on a scale. The raters did not intend that a scale be drawn between *insane* and *well,* with graded points such as psychotic, psychopathic, neurotic, compulsive, psychosomatic, and mildly depressed. On the contrary, some patients with a depression or an obsessive-compulsive reaction could be more functionally impaired than many ambulatory schizophrenics.

Rennie and Kirkpatrick began, then, with the problem of applying a scale for rating the respondent's mental health.

In a standardized manner the project office staff prepared a summary of relevant portions of each interview. Each interview Summary[2] was in two parts, the first including such data as the respondent's age, sex, marital status, age when first married, health, subjective psychological symptoms, psychosomatic complaints, evaluation of health in recent months and also five years earlier, personality orientations, and the interviewer's observations about the respondent. On the basis of this material each psychiatrist assigned the respondent to one of seven graded categories of symptom formation. This was named mental health Rating I.

This tentative rating as can be seen, was based essentially on symptomatological evidence alone. Mental health Rating II, similarly divided into seven levels, had the benefit of all information bearing on life

functioning and sociocultural environment.[3] The rationale for the separate ratings was one advanced by the Study's sociologists. The aim was to provide at least one rating for each respondent which would be as free as possible from any bias that might enter through knowledge of his socioeconomic level or data bearing directly on other independent variables. In cases where the psychiatrist's Rating II was different from that assigned as Rating I, he was required to indicate the considerations leading to this shift. The reason for this was to make possible later analysis of the influence of such sociocultural data upon the rater's judgment. Eventually the results of the separate ratings (II) by these independent judges were systematically adjudicated on criteria set forth in Appendix F.

The final adjudicated classification of symptom formation contained six categories:

1. Well
2. Mild
3. Moderate
4. Marked
5. Severe
6. Incapacitated

} Impaired

QUALIFYING CONSIDERATIONS

As we entered upon the rating task, many questions of meaning and validity were in our minds. As in any study of mental health, we had to work without the kinds of instruments available in other branches of medicine.

In carrying out the rating process, we were performing and learning a new technique at the same time. It was something like diagnosis, and yet it was definitely not diagnosis, but rather an assessment of probability based on a kind of data that lacked much of the information upon which clinicians usually rely. Outstanding as a question mark was the fact that we never saw or talked to the respondents, as would have been the case with patients.

Attempts had to be made by each of us to allow for his own biases and predilections, any tendency he might have to read one kind of disorder rather than another into the incomplete information. Also taken into account were apparent diversities in approach of the interviewers, and especially the attitude of the respondent himself toward the interview. There can be no doubt that some of the latter could not or would not reveal certain aspects of themselves. Aside from intent, there were matters such as the following: A person says that looking down from high places makes him nervous. This could be an indication of a very careful answer (most people are made at least a little uneasy under such

circumstances), or it could be a clue to a phobic disorder. Decision in such a matter had to depend on the impact made by the rest of the responses on the rater. Observations by the interviewer of the respondent's alertness, hostility, and level of interest had to be taken into account in judging the actual content of the responses to the questions.

With inferences and judgments of this order, corrections were attempted, hopefully in the right direction, in order to counterbalance what at times could be misleading or insufficient information if taken at its face value.

Another problem faced was the matter of judging current mental health. This made it necessary to differentiate evidence relating to past and present functioning. In some instances this was not difficult, but in others it was. Consider, for example the problem of interpreting a respondent's comment that he dislikes his line of work. Is this an expression of many years of loathing or an expression of annoyance which arose today?

We had to recognize, in short, that we were undoubtedly missing and misinterpreting evidence bearing on both mental illness and mental wellness. At the same time we could not take comfort in the thought that these two opposite tendencies would cancel each other out. Since our effort in making each rating was *to lean away,* when in doubt, from judgments of illness, it was our feeling that we were missing cases of disorder rather than misrepresenting those identified as well. For obvious reasons, no questions with regard to sexual history or similarly sensitive matters likely to abort the interview had been asked. It seemed to us, to take some examples of symptom types, that the individual with mild symptoms of paranoid schizophrenia would not be apt to reveal himself in the interview—or in any other type of single-session inquiry. The same applies to sociopathic traits and alcoholism. With some of the records studied and rated there was a tantalizing feeling that the respondent never really came into focus, remained an elusive shape hidden below the surface of the words.

Such were many of our doubts and skeptical reflections. At the same time it was apparent to us that many of the Summaries of the interviews were very easy to rate—especially those at the extremes of the mental health scale. The evidence appeared overwhelming and not open to reasonable doubt. As the rating progressed and our experience increased with the technique we had developed, we became more and more convinced that what we were doing had meaning. This conviction is of course a subjective impression, but we think it has some importance nonetheless, since it is also based on clinical experience. All three of those concerned—Rennie and the two raters—became overwhelmingly convinced of this.

It should be borne in mind, however, that while we became convinced the results had meaning, we also came to feel strongly that this mean-

ing is a subtle and complex matter and that interpretation based on statistical treatment of the ratings needs to be made with great care. In particular they must not be considered as equivalent to psychiatric diagnosis. Throughout the volumes of this Study, the data must be evaluated as *a rating of mental health based on the rating psychiatrists' perceptions operating through a questionnaire instrument.*

In line with this the writers are not prepared to say that the associations to be reported in this volume between the mental health ratings and various sociocultural variables constitute unequivocal proof about etiology with reference to mental disorder or mental health. What they do offer, however, are bases for some exceedingly suggestive interpretations, for defining new research questions to be attacked in a more refined and specific manner, and finally, evidence—though not conclusive evidence—for a number of promising propositions and hypotheses.

FOOTNOTES

[1] Three questions can be interpreted as reflecting mood: (G40) "On the whole, life gives you a lot of pleasure. Agree-Disagree." (G43–1) "You sometimes can't help wondering whether anything is worthwhile anymore. Yes-No." (A7–6) "I often worry about [among other subjects suggested] loneliness." In their different contexts and coupled with the interviewer's direct observation, these were considered clues to depression.

[2] For a full listing of information presented to the raters see Appendix E.

[3] Appendix F provides cases whereby the reader may observe the application of the ratings so categorized.

PART II

Midtown Portrait

CHAPTER 5 *The Scene and the People*

Leo Srole

The four preceding chapters have been in the nature of prologue notes to the reader, identifying the major conceptual and procedural equipment put to ensemble use in this study. It is now time for the program proper, namely the piece-by-piece notation of what we learned about mental health by soundings made in one particular human setting with these specific instruments. The setting mentioned is a place we call Midtown. However, before considering the mental health results forming the narrative core of this report, we must pause to apprehend certain salient qualities in the character of that place. The Study's Sociography operation, outlined in Chapter 3, was conducted for this purpose and gathered the materials germane to the three chapters that follow.

Given the operation's selective scope, what we report here is largely descriptive in nature, in essence a community "portrait" of a kind that perhaps would be better drawn through the novelist's or playwright's special flair for conveying character in action. The sociologist's eye here takes a panoramic view and can accordingly bring out only gross contours in the social landscape, rather than fine shadings and sharp details. More penetrating understanding of one of the most complex of American communities would require research far more comprehensive and intensive than was possible under the Study's modest Sociography program.

THE CONTEXT

Grasp of a great city in its "unspeakable complexity," as a *New York Times* editorial has phrased it, poses problems even for the observing lifelong resident. Sociologists have recently spoken to this point: "It is apparent that the [city's] complexity of physical layout and structure is immense; that [its] social structure is so complicated that even research teams of sociologists can do little more than grasp the outlines of significant groups and their interrelationships. And who ordinarily can hope to know or appreciate the whole social history of a city?" [1]

The editors of a national magazine, dedicating an entire issue to New York City, caution us in a related vein: "What stuns at first in New York is the overwhelming *number* of small worlds (music, clothing industry, shipping, the United Nations, theater, etc., etc.) which overlap and intertwine in one city, so that for the newcomer who does not recognize the threads, does not see the pattern each world forms for itself, the city is simply megalopolis, confusion compounded, chaos." [2]

Confronting a much less "stunning mass," as encompassing an observer as John Gunther could concede: "About Chicago itself there is so much to be said that the task of compression becomes hopeless." [3]

This task may seem somewhat more hopeful for Midtown, a single residential world harboring only one-fiftieth part of the New York City population. But Midtown is a flesh and bone segment of the City and cannot possibly be delineated or encompassed apart from it.

Thornton Wilder's memorable drama *Our Town* opens with a monologue by a stage manager commentator, who identifies the play's locale as "Grover's Corners, New Hampshire, the United States of America, Western Hemisphere, the Earth, the Solar System, the Universe, the Mind of God."

Telescoping and reversing this expanding order somewhat, we might gradually "zero in" on Midtown, starting from a national point of departure. If we were to draw a population map from this vantage point, we could first indicate that peppered thinly across the country's whole expanse were farming families aggregating some 25 million people;[4] in small clusters widely scattered among these were another 30 million persons in nonfarming families gathered in thousands of rural villages and "Grover's Corners" towns with fewer than 2,500 inhabitants; both, together, aggregate about 36% of the national population.

At the opposite pole from such extreme human dispersion, we could next mark the 14 *standard metropolitan areas* with highly compact populations exceeding 1 million each.[5] These large metropolitan concentrations, their combined land space figuratively compressible into one of the smallest of the 50 states, hold a total of 44 million people, or almost 30% of the American populace. Among these, the largest metropolitan complex of all comprises 17 counties designated by the Census Bureau as the "New York–Northeastern New Jersey area." Here have crowded a population of almost 13 million, its workers representing about one in every ten of the entire United States labor force.

Wedged into this 4,000-square-mile topography is the corporate entity of New York City, covering 8% of the area's land but occupied by 60% of its people. The colossus among American cities, New York, within its 315 square miles of land, houses a population of nearly 8 million, exceeding that of all but 3 of the Union's 50 states. This bare statistic,

of course, misses the salient fact that the City is functionally a generating, terminating, or flow-through point of all manner of traffics, human and symbolic, for the region, the nation, and the world,[6] a fact we need hardly pause to document with specifics.

Of decisive importance to this network of far-flung traffic junctions is the compression of most of the City's diverse economic functions within its hub borough of Manhattan, an island of 22 square miles, too small to be separately delineated on any map of the United States. The City's working population[7] (1957) approaches an estimated 4 million people, including the self-employed. Of these, about 2.7 million, or almost 70%, conduct their work in Manhattan. To appreciate the specialized nature of this concentration, we might briefly note a few of the major fields which engage Manhattan's working (employed and employer) population. An estimated 375,000 are in finance, insurance, or real estate. Approximately 325,000 work in retail shops and department stores, perhaps another 250,000 in wholesale trade. Over 200,000 are employees of the government—municipal, state, and Federal. Nearly 400,000 are in the "services" category of functions. Employees of manufacturing enterprises number 550,000 people, including office personnel as well as factory workers.[8] Obviously, this is not an inclusive list, but it is sufficient to highlight a characteristic common to the core of big cities, and reaching the highest point of specialized development in the Manhattan economy. We refer to the advance to dominance of the administrative, distributive, and services functions and the retreat to outlying areas of all but the lightest forms of factory production. In the imagery of the Manhattan workaday street scene, the leather brief case has displaced the tin lunch box.

We have noted the concentration of the City's working population within Manhattan. However, of the City's total office floor footage in 1957, roughly 90% was confined to an area comprising about 1% of its land space, namely, a 1-mile wide strip of Manhattan that we designate the *Central Business Section.*[9] In this narrow belt, which has been called the heart of the national economy, regularly work almost 2.5 million people.

For briefer transient purposes of business, shopping,[10] recreation,[11] or other services, there also converge here throngs of New Yorkers, suburbanites, and out-of-town visitors, numbering on peak days perhaps 1 million persons. Thus, the weekday pedestrian traffic in the section's 4 square miles numerically often approaches the 3.6 million inclusive 1950 population of Chicago, the nation's second largest city.[12]

Sheltering most of this mass of human beings, during daylight or evening hours, are the section's thousands of commercial buildings. Seen at a distance, these form Manhattan's vaulting skyline, the City's craggy

promontory that has inspired more graphic art and photography, poetry, and prose than perhaps any other man-made phenomenon on earth.[13]

Midtown, our portrait subject and our object of research study, is a Manhattan district almost wholly residential in character. From its position adjoining the midtown portion of the Central Business Section[14] comes the rationale for its pseudonym.[15] That position also defines its general location as more or less midway up the length of Manhattan Island, and through that locus, its stand near the business and traffic vortex of New York City and the New York–Northeastern New Jersey metropolitan region. However, from the inclusive national perspective Midtown, with its 175,000 residents, equivalent in size to the population of Hartford, Connecticut, or Nashville, Tennessee, can also be viewed as a microscopic slice of the large segment of America that inhabits the biggest metropolitan areas.[16]

HOUSING: DENSITY

One direct consequence of its location for Midtown can be read on the yardstick of gross population density. Figured in terms of individuals per square mile, the population density of the United States as a whole is 50, of the New York–Northeastern New Jersey metropolitan area 3,300, and of New York City proper about 25,000. However, the accessibility of transportation to the pyramiding economic and recreational facilities over the small patch of Manhattan's Central Business Section has had strikingly different consequences for the City's five boroughs. For example, in Staten Island, the borough most distant from Manhattan and until 1965 accessible only by ferry boat ride over a 5-mile expanse of harbor, gross population density per square mile is 3,200. As the borough that has the most recently constructed rapid transit lines to Manhattan, Queens has a density of 14,000 people per square mile. With the oldest subway arteries to Manhattan, the Bronx and Brooklyn have gross population densities of 34,000 and 36,000, respectively. For Manhattan itself, gross population density figures to about 90,000 per square mile.

Gross population density is calculated on the basis of an area's total land space; the term is an understatement when, as in the case of Manhattan, most of the land is used for purposes other than habitation. *Net population density* is calculated on the basis of total land area in parcels put to residential use. Applied to Manhattan, average net population density is actually 380,000 people per square mile of residential land.[17] Or, stated in terms that can be more readily grasped, on the average 100-by-100-foot residential plot there live 136 individuals.

If we were to look out from the observatory of the Empire State

Building, towering above Manhattan's Central Business Section, population densities from the City's rim inward could be seen increasing progressively toward Manhattan's core residential areas immediately adjacent. On this panorama, Manhattan's Central Business Section assumes the likeness of a gigantic geodemographic magnet, its population attraction being strongest at its immediate borders and diminishing more or less directly with increasing distance and travel time. This magnetism will repeatedly be found to be a key to understanding the characteristics of Midtown as a locale, as a population, and as a community.

If resident population density climbs with proximity to the office skyscrapers of Manhattan, this of course also reflects the mounting vertical dimension of its residential housing. A partial measure of this dimension is found in a classification of residential structures according to the number of dwelling units they contain. Table 5-1 gives the classification applied and the distributions reported for the City's boroughs and Midtown by the 1950 United States Census of Housing.

Table 5-1. Distribution of Residential Buildings in Midtown and the Five Boroughs by Number of Dwellings (1950)

	Number of dwellings per building			
	1–2	3–4	5 and over	Total
Staten Island	82.1%	8.5%	9.4%	100%
Queens	58.7	8.8	32.5	100
Brooklyn	32.3	19.6	48.1	100
Bronx	13.8	7.6	78.6	100
Manhattan	2.6	2.8	94.6	100
Midtown	3.0	2.0	95.0	100

We note that at one extreme the populations of Staten Island and Queens live predominantly in one- or two-family houses; and that at the other extreme, the people of Midtown, like those of Manhattan generally, make their homes almost entirely in buildings with five or more dwellings. The observant visitor to Midtown will fill out the picture in far more graphic detail. He encounters three- or four-story single-entrance structures, some few occupied by one or two families, many divided into six or more dwellings. The greatest part of the residential land space he finds occupied, row-on-row, block after block, by five- and six-story multi-entrance walk-up apartment houses. Of course, these two types of buildings he would also encounter in high-density boroughs like the Bronx and Brooklyn. However, far more prevalent in Midtown and residential Manhattan generally, and not reflected in the Census Bureau's classification, are the elevator-served "cliff-dweller" apartment buildings,

in some new instances reaching upward to 30 floors.[18] According to press reports, land for the newest of these structures was acquired at a cost varying between $100 and $225 a square foot, suggesting something of the enormous pressure of demand for living space.

The visitor's eye would catch such additional details as buildings set close to or flush with the front sidewalk, "elbowing" each other at the flanks with little or no intervening space (some occupying 90% of the entire site), to form almost unbroken walls of brick, mortar, and glass. If he explores their interiors systematically to check the number of rooms in their dwellings, he finds over-all that only about one-fourth of the households have five or more rooms (i.e., two or more bedrooms), approximately one-fourth have four rooms,[19] another one-fourth have three rooms, and the remainder are about equally divided between one (or "one and a half") and two rooms. Accordingly, about three in every four dwellings provide no more than one room designed for sleeping purposes.[20] From such observations, the visitor comes away with a vivid sense of record population density achieved by both horizontal compression and vertical "stacking" in Midtown's housing.

HOUSING: SOCIAL CLASS HISTORY

Another striking aspect of Midtown's housing requires a rapid retrospective glance over Manhattan's economic and social history. By way of preliminary, several decisive facts must be taken into account.

First, separated from Brooklyn, Queens, and Staten Island by wide rivers that until 1883 could be crossed only on small ferry boats, Manhattan was by statute an independent city until 1898.[21] Long before that, when the other boroughs were still congeries of scattered rural villages and suburban satellites, Manhattan had become the nation's first city in population size and economic power.

Second, through the whole of the nineteenth century Manhattan's bursting economic expansion created a large class of business wealth that it held residentially clasped to itself. This group, in turn, placed its indelible stamp[22] upon the Island, to a degree probably unmatched by its counterparts in other American cities.

With enormous economic thrust, Manhattan's population soared from 96,000 in 1810 to 515,000 in 1860 to a high-water mark of 2,300,000 in 1910. This seam-splitting growth was channeled in the only direction open—northward on the tight corridor of the Island, then still farm land or marsh, with rather noteworthy consequences.

During the late eighteenth and early nineteenth centuries most of Manhattan's work places were crowded around the southern point of the Island, and nearby, along the edges of both rivers principally, were gathered the homes of the "gentility."

The harbor's gateway to the hinterland via the new Erie Canal brought a surge in Manhattan's maritime industry, which spread northward, lacing the Island's waterfronts with wharves, shipyards, warehouses, ship chandlers, and the like. These in turn displaced the mansions of the well-to-do, who soon resettled on the nearby northern residential outskirts at a point roughly midway between the two rivers.

The business center (of finance, wholesale and retail trade, and related fields) in the meantime was likewise expanding northward, and also on an axis approximately halfway between the bordering rivers. There it soon caught up with and dislodged the second area of "fine homes," often converting the latter for business purposes, now forcing the affluent due North in a leapfrog to the margin where Manhattan's new streets and avenues were cutting into farms, goat pastures, potter's fields,[23] and clusters of squatters' shanties.

This pattern, to be repeated again and again[24] through 150 years, involved two elements: (1) the persistence of wealthy families in resettling more or less cohesively midway between the rivers (of course within easy travel distance of their offices), and (2) the forward drive of the Business Section on the same axis, to push the "elite" residential district steadily ahead in a compact three-block-wide lane that centered first on lower Broadway, next on lower Fifth Avenue, and then along the reaches of Fifth Avenue progressively above.[25]

When this long migratory trail of the best homes reached Central Park (59th Street) just before the turn of the twentieth century, with the Central Business Section continuing to advance in the rear, the moneyed classes began to move around the Park, first to the west and later to the east, fanning out from there toward the flanking rivers. In the years before World War I, with Manhattan's empty land consumed, this group, for the first time on a large scale, started to abandon the traditional "castle" of the one-family town house and took to the high apartment buildings,[26] a development that Bostonian Oliver Wendell Holmes incisively characterized as "intentional domicide."

The historic pattern[27] just reviewed, necessarily in highly simplified form, was of course marked by local deviations arising from special circumstances we cannot pause to describe here. However, their effect was to divert the obliterating movement of the Central Business Section around certain exclusive residential "islands" that have survived (now largely converted into apartment houses) behind the front line of its advance.[28]

Moreover, with Manhattan solidly built up, in recent decades we find whole blocks of middle- and even low-rent housing being remodeled or demolished and transformed into high-rent areas. As compared with the situation a century ago, therefore, the residential cohesion of Manhattan's top income group has now been broken into a number of scattered en-

claves, large and small, old and new, but all within short travel range of the Central Business Section.

This summary account has sketched the roots of a central fact about Midtown as it is today, namely, that within its boundaries are to be found a portion of one of the largest of these enclaves and a scattering of several smaller ones, all the end result of a long process in Manhattan's development, and all reflecting the silver cord of nurturance that binds their residents to work places beneath the Business Section's skyline.

To turn the historical view toward the other end of the social spectrum, the "hewers of wood" in the swelling Manhattan community of the early nineteenth century were first provided barrack-like quarters in "breweries, old warehouses or any structure with four walls and a roof" [29] under conditions approximating steerage in the ships that brought most of them to the City.[30] Then, at about mid-century emerged the prototype of the five- to six-floor walk-up tenements devised by jerry-building experts at crowding a parcel of land.[31] These were predominantly constructed on open land adjoining the river frontages of maritime docks and all their appendages. As the laboring population multiplied and remultiplied, the tenements spread steadily northward (in strips several blocks wide), along one river toward the upper reaches of the Island. Needless to say, access to place of employment was a consideration even larger for calloused workmen than for the well-groomed businessmen who, in the earlier period, appeared at their offices in top hat and morning coat. In this light the prodigious nineteenth-century growth of Manhattan's economy—a giant cramped into a procrustean space by natural barriers on all sides—forced poor and rich alike, in an era before the development of rapid transit, to settle hard on the flanks of its habitat. With the coming of new forms of urban transportation, Manhattan's economy by its sheer giantism continued to hold its teeming population density and residential congestion—somewhat changed, to be sure, since 1910, as the land base in residential use has shrunk and the land base in business use has swelled further.

Tenement housing during the period of our field research was still heavily represented in Midtown, although it had been receding since 1930, either to be replaced by apartment buildings or to be remodeled for middle- or high-income occupancy. As to the condition of Midtown's remaining low-rental tenements, we have indications from the 1950 United States census of housing reports.

By census criteria a dwelling is substandard if it (1) lacks a private bathroom, or (2) lacks running water, or (3) is dilapidated, i.e., "run-down or neglected, or of inadequate original construction, so that it does not provide adequate shelter." By these criteria, 18.7% of Midtown's 65,000 occupied dwellings in 1950 were in substandard condition. The corresponding figure for Manhattan as a whole was 18.5%. It may also be

added that among Midtown's 190 residential blocks, 35 of these had between 20 and 94% of their dwellings in such condition, most of them to be found in tenement-type housing dating, in many cases, to the nineteenth-century era of "dismal, claptrap" construction.

We have less information at hand about the developmental course of Manhattan's middle-class housing. We gather, however, that in the latter half of the nineteenth century this class was predominantly accommodated in the solid rows of three- or four-floor "brownstone-and-stoop" structures characteristic of other seaboard cities during the period. In terms of land space occupied, these were also a highly prevalent type of housing in Midtown during the period of study. However, many had either been remodeled for high-income occupants or had been cut into smaller dwellings for low-income families. By and large, therefore, Midtown (like Manhattan as a whole) in its over-all housing shortage relative to demand, has a particular shortage of middle-bracket dwellings. Its middle-class group is accordingly scattered among the better kept brownstones, the older, smaller apartment houses, and the refurbished tenements.

POPULATION COMPOSITION

From the above housing review it can be gathered that within its great population density Midtown, like the rest of Manhattan, today presents a picture of enormous socioeconomic diversity, its residents covering the entire range from families with social-register lineage—some associated with the top fortunes in the land—to families quartered in tenements now near or at the slum level.[32]

Originally, these social extremes were settled at opposite sides of the study area. Subsequently both expanded toward the center. Where their housing converged, the effect was often a juxtaposition, back to back and even side to side, of downgraded brownstones, near-slum tenements, upgraded brownstone town houses and luxury apartments.[33] Such cheek-by-jowl contrasts have grown in recent decades. Builders for the wealthy, having discovered the light, air, and vista advantages of the riverfront—once occupied by wharves, warehouses, breweries, and slaughterhouses —have erected "lavish" apartment houses near tenements of the poor.[34]

In this light, Midtown fits the specifications of heterogeneous, high-density residential areas that sociologists have designated as "gold coast and slum" and have found adjoining the central business section in other metropolitan cities such as Chicago, Detroit, New Orleans, Baltimore, Philadelphia, and Boston.[35]

It is generally characteristic of such areas that their population is almost entirely white, reflecting the residential segregation of Negroes in more peripheral sections of the metropolis. Sharing this characteristic,

Midtown is 99% white. Manhattan, on the other hand, is 20% nonwhite—this population being principally confined to the Harlem section.

Although the metropolitan "gold coasts" are predominantly nurtured by wealth made in the economy of the big city itself, a significant number of their residents have been recruited from families who had created their wealth in smaller centers and then migrated to the metropolis.[36]

This underscores one of the crucial forces in the development of the metropolis, namely the power it generates to draw migrants to itself. Its well-known capacity to attract immigrants from abroad will presently be documented for Midtown. Its pull on the native-born of the American hinterlands, here designated *in-migrants,* lacks such census documentation. However, from our own Home Interview Survey we can estimate that among Midtown adults (in the 20 to 59 age range) approximately three in ten are American-born in-migrants from varying distances beyond New York City's borders. Of these some 30% are from families of apparently high socioeconomic status, 53% are of middle-range origins, and only 17% had fathers who were in the blue-collar occupations.[37] The corresponding proportions for age 20 to 59 Midtowners born in New York City are 11, 31 and 58%, respectively.

The gravitation to American metropolitan centers from abroad, particularly during the period 1850 to 1920, helped to recruit indispensable manpower for the expansion of these cities and for the surging industrial growth of the American economy.[38] Hence, the lower-class levels in all big American cities outside the South in time were predominantly occupied by a variety of immigrant groups. Upon arrival in the city, the first area of settlement of these ethnic groups (as we shall refer to the immigrants of each national origin, their children, and grandchildren), was usually on one edge of the original nucleus of the central business section, e.g., Manhattan's Lower East Side—once a "rustic suburb for well-to-do Anglo-Saxons"—Chicago's "old" West Side, and Boston's North End. When the pressures of additional newcomers mounted, tenement quarters for them were built outward in other directions. In time, these coalesced with the newer "fashionable" sections that arose in the van of the expanding business section. Thus, heavy ethnic representation and diversity have been characteristic of the laboring class in these metropolitan gold coast and slum areas. An excellent case in point, Midtown has been described in the local press as "a polyglot district which crosses all lines of wealth and nationality."

In both Manhattan and Midtown, the foreign-born constitute about one-third[39] of the white population and derive from every country on the map of Europe, predominantly Germany, Austria, Ireland, Italy, Hungary, the United Kingdom, and the Slavic countries of Eastern Europe. Numerically, some of these immigrant groups are represented in the Mid-

town area in about the same proportions as in the whole of Manhattan, while some are more heavily concentrated and others less so.[40]

In terms of another aspect of their origins, Midtown's immigrants in the 20 to 59 age range are *not* predominantly from rural places, as were their nineteenth-century predecessors. About one-fourth of these derive from cities with populations of over 500,000. Approximately 40% are from smaller urban areas. And only one-third stem from farms or villages. In economic origins, judging by occupational level of father in the homeland, about 60% are from the blue-collar class, 30% from the lower white-collar class and about 10% from the business and professional class. Finally, although several of the nationality groups are entirely Catholic in religious background, most are divided among Protestantism, Judaism, and Catholicism. Thus, Midtown's immigrants, in national variety, in rural-urban derivations, in economic origins, and in religious backgrounds, present a picture of considerable heterogeneity.

Of course, the American-born children of immigrants, i.e., the second generation, are also well represented in Midtown, numbering according to the 1950 census 29% of the area's population. A sizable part of these (about one-third) are ethnically mixed, i.e., the two parents were of different nationality origins. Moreover, a significant number (30%) of this generation are not derived from the local ethnic groups as such, but are themselves in-migrants to New York City from other American communities. Given the incisive impress of American acculturation, these children of immigrants add to the over-all diversity within the several ethnic groups of Midtown.

We carry classification of the ethnic population to the third generation, i.e., to the grandchildren of immigrants. Unfortunately, the United States census does not specifically identify this element. From our Home Interview Survey we can estimate that among Midtown adults between the ages of 20 and 59, some 4% had U.S.-born parents and four immigrant grandparents of *like* nationality roots, and another 12% were descended from U.S.-born parents and immigrant grandparents of *diverse* nationality origins, together totaling 16% of this population. From diversity of cultural descent and further transmutation by the absorptive processes of American life, this third generation has become largely indistinguishable, except in the religious sphere, from the native, Old American stock. As defined by the operational criterion of families in the country four or more generations, the latter number about 14% of Midtown's adult population in the 20 to 59 age span. It might be added that U.S.-born in-migrants to New York City, constitute 30% of Midtown's ethnic second generation, 47% of the third generation, and 72% of the Old American group.

The third generation, by its largely completed sociocultural assimilation, enlarges the patchwork heterogeneity and fragmentation within

each ethnic group. Accordingly, the evidence offers no support to inferences either that these groups are culturally homogeneous or socially monolithic communities or that they are residentially insulated in their own quarters of the area, outside the mainstream of American life.

We do not thereby imply that the ethnic element has become invisible on the streets of Midtown. Although every ethnic group has families dispersed through most of the area's 190 blocks, there are separate clusters of blocks where each group—principally its immigrant elders—is more heavily settled than elsewhere in Midtown, but in no case approaching a point where it is in a numerical majority.

Moreover, in the neighborhoods where three of Midtown's largest nationality groups are most heavily represented, the observer will find a gathering of institutions directly or indirectly reflecting the particular ancestral culture, such as restaurants, bakeries, groceries, recreation halls, travel agencies, and the editorial office of its foreign-language newspaper.

The evidence of these institutions should not be misread by the visitor. In part they serve the local group, but they also serve group members living in other areas of Manhattan and in adjoining boroughs,[41] as patrons of the newspaper, the restaurants, and recreation halls bear witness. In this respect, they function as centers of the dispersed city-wide nationality group, rather than as exclusively local institutions of the Midtown group.

Conspicuous in the over-all portrait of the Midtown population is its extreme heterogeneity in both socioeconomic status and ethnic background. It need only be noted, further, that these aspects, as elsewhere,[42] are closely intertwined. That is, from immigrants through the second and third generations in our sample population, there have been progressive upward advances from predominantly lower socioeconomic status to predominantly middle class status, with the Old American group holding the largest representation in the upper class.

Religious background is a demographic characteristic not covered by the decennial United States census. However, in our age 20 to 59 sample of Midtown's adult population we find that almost half (48%) are of Catholic parentage, these predominantly of lower socioeconomic origin, approximately one-third are Protestant in descent, and one-eighth are of Jewish background, both of the latter groups deriving principally from middle-status parents.[43]

The perceptive observer on the streets of Midtown during a good autumn weekend is soon impressed by the number of children he encounters, that is, the *small* number. The impression is confirmed by the United States Census Bureau report that whereas children under the age of 15 represent almost 28% of the American urban[44] population, they comprise only 15% of Midtown's residents.

Several factors are found responsible for Midtown's striking deficit of children, a characteristic shared by other metropolitan communities. We would first emphasize that its relatively small proportion of children is not an artifact of an excess of old people. In fact, the proportion of Midtown's population who are over the age of 64 is almost identical with that in the white Manhattan population and in American urban places as a whole, i.e., about 10%.

One of a series of clues to the problem is to be found in the census report that, relative to the white population over the age of 14, never-married individuals number about 22% in United States urban places and 32% in Midtown.[45]

Another facet of this phenomenon is the number of one-occupant dwellings, which we refer to as *singleton* households. In American urban places 11% of all households are singleton, as compared with 25% in Midtown. Parenthetically, this is a characteristic particularly associated with residential areas adjoining the central business section in metropolitan cities, as was observed in sociological studies of Chicago several decades ago.[46] Thus, the small proportion of children in Midtown is in part explained by the large number of unmarried[47] and exmarried adults.

A second clue is discovered in the census datum that 35% of its dwellings have two occupants, consisting in largest part of childless couples. Following this lead into the sample of adults studied and focusing down to the wives between the ages of 40 and 59, from whom further births are unlikely, we find that one-third are childless and another 25% have had only one child,[48] a condition equally prevalent among the younger (20 to 39) wives. Thus, the large proportion of unmarried adults, and the majority of its married couples who have either one offspring or none, together seem to account for the relative scarcity of children in the Midtown population.

Linked to this scarcity is another generalized characteristic of the American metropolis, namely, its high proportion of employed females.[49] In Midtown, for example, women constitute 42% of the resident employed, as compared with 32% in the national white labor force employed in non-agricultural work.

Contributing heavily to Midtown's resident employed force are its married women. To judge from our own sample of adults, 53% of Midtown wives hold either full-time or part-time jobs, as compared with 26% among white married women in the national urban population. It can be safely assumed that this contrast is not unrelated to the low birth rate observed among these Midtown wives.

Another condition in the American metropolis associated with the large female representation in its labor force is the sheer fact that here women outnumber men by a significant margin. In the Midtown population as a whole, for example, there are 125 females to every 100 males. This

disparity prevails not only above the age of 60, where is reflected the decidedly greater capacity of the "weaker" sex to survive the "stronger"; it appears as well on every age level between 18 and 60. That a local deviation from the Mendelian law of equal sex chances is not involved can be concluded from two facts. First, among Midtown's children (under age 15) there are indeed 100 girls to every 100 boys. Second, in our sample of Midtown adults (age 20 to 59), those born in New York City are almost equally divided between the two sexes (105 females to 100 males). On the other hand, among the sample's foreign-born element the female-male ratio is 160:100,[50] and among its American-born in-migrants this ratio is 175:100. The reasons for such disparities in the sexes are matters to which we shall return in Chapter 10.

MIDTOWN: SPECIAL OR GENERIC CASE?

Our overview of Midtown as a locale and a population raises a question whether this entity is a special case lacking general significance.[51] This is a many-faceted question that also pervades the remaining chapters in Part II of this book and therefore must be tentatively held in abeyance.

However, we can here address ourselves to two aspects of the problem posed. In one direction, we have already suggested a number of characteristics that Midtown seems to share with "gold coast and slum" areas in other of America's largest cities, e.g., proximity to the central business section, peak population density, racial homogeneity, great socioeconomic and ethnic heterogeneity, a deficit of children, an excess of single people —particularly of females—and heavy representation of women in the labor force. Further comparative research must determine how far the similarities and differences observed among these core residential areas warrant their classification as a species of the metropolitan genus within the family of American communities. On the basis of present general indications pointing to striking similarities in the historical development of these areas, it seems likely that such warrant will be found. In that event, Midtown would stand not as a unique case but as a member of a species, to be sure a small and highly specialized species.

In another direction lies a specific query as to how far Midtown, racially almost wholly white, is representative of New York City's white population. To simplify control of the racial factor we have addressed this question to a demographic comparison of Midtown, the white population of Manhattan, and the borough of Queens, itself 97% white. The comparative data appear for the reader's inspection in Appendix G.

On 11 of the 13 housing and demographic yardsticks there applied we find Midtown and white Manhattan standing closely arrayed in like distributions, which more or less contrast with those of Queens. Only in

its ratio of females to males is Midtown somewhat higher than the two other communities, linked with a corresponding difference between Midtown and white Manhattan in their percentages of employed females. And we would add that all three communities to a certain extent differ among themselves in the nationality composition of their immigrant populations.

All told, we can conclude first that in nearly all respects covered by the 1950 census reports, Midtown is decidedly different from Queens (as also, in varying degrees, from Staten Island, the Bronx, and Brooklyn); and second, that with the exceptions just noted, the Midtown population in all these respects is rather strikingly like the 1.4 million Manhattan non–Puerto Rican whites among whom it is a 12.2% segment.

Accordingly, the question raised can be given the answer that although in demographic respects Midtown is hardly representative of New York City's inclusive white population, on the evidence available it appears, on the whole, to be not unrepresentative of the white population in its own borough. With that observation as warrant, the remaining chapters of Part II will draw materials from sources that refer either to Manhattan in general or Midtown in particular.

SUMMARY

Facing the impossibility of catching and projecting the complex character of a city by the devices of words, we first attempted to locate Midtown in a series of spheres to which it intrinsically belongs, namely, metropolitan America, its metropolitan region, the City of New York, and Manhattan.

We reviewed such salient elements in Midtown's human environment as its position astride the City's vast network of economic arteries, its high population density, the horizontal compression and vertical extension of its housing, and the great socioeconomic, ethnic, and religious diversity in its demographic make-up.

Following the clue offered by its scarcity of children, we uncovered Midtown's large contingent of unmarried adults, the low fertility of its families, the heavy representation of wives in the labor force, and the unbalanced number of its adult males and females. Finally, we noted that on a variety of criteria Midtown seems to be representative both of similarly located core residential areas in other large American cities and of the large white population in its home borough of Manhattan.

Midtown as here sketched is caught in a still photograph taken at a narrow span of time. However, these outlined characteristics are themselves concatenations of individual and group processes that have moved a variety of people, under a diversity of motives, to live in Midtown

rather than anywhere else. The next chapter undertakes to shift from the static to the dynamic view of Midtown's inhabitants as residues of much larger population reservoirs.

FOOTNOTES

[1] R. R. Wohl and A. L. Strauss, "Symbolic Representation and the Urban Milieu," *Am. J. Sociol.*, vol. 63, no. 5, pp. 523–532, March, 1958.

[2] *Holiday*, October, 1959, p. 49.

[3] *Inside USA*, 1947, p. 369.

[4] Unless otherwise indicated, all population and housing figures presented hereafter will have as their source the U.S. Census Bureau reports of the Seventeenth Decennial census of 1950.

[5] As defined by the Census Bureau, the standard metropolitan area is composed of (1) a "central city" with more than 50,000 people and (2) contiguous counties which, by certain criteria, "are essentially metropolitan in character and socially and economically integrated with the central city." We are here arbitrarily applying the 1 million population criterion to differentiate the fourteen largest among the nation's 168 metropolitan areas.

[6] Over a century ago, James Fenimore Cooper observed: "New York is essentially national in interest, position, pursuits. No one thinks of the place as belonging to a particular state, but to the United States." (Quoted in Alexander Klein (ed.), *The Empire City*, 1955, p. xxi.) Now we are told: "The towers of Manhattan cast their shadows not only over the entire nation but everywhere on the globe. For New York City has become the crucible and nerve center, the focus and symbol of man's civilization on earth." *Ibid.*, p. xxi.

[7] *Working population* refers to all people who carry on gainful employment within an area, whether domiciled in the area or not.

[8] The figures in this paragraph are adapted from those provided by New York City Planning Commission publications. However, commission data were confined to wage and salary earners, excluding the self-employed. We have made estimates of the distribution of the self-employed among the several fields named above and have adjusted the commission's figures accordingly.

[9] Actually, this consists of two subsections of commercial concentrations locally often referred to as *downtown* and *midtown*. The latter, as a rough approximation, covers the area southward from 59th to 14th Street, between Ninth and Third Avenues. The former, also by way of approximation, includes the area southward from Houston Street to Battery Park at the end of the Island, between the Hudson River and a line extending southward along LaFayette, Baxter, and Chamber Streets to the East River. Official city documents employ *Central Business District* to refer as a rule to all of Manhattan south of 60th Street. The lines we have drawn to define the two areas designated together as the Central Business Section exclude most of the 630,000 people who make their homes in the predominantly residential areas south of the 59th Street line.

[10] It has been said that this district contains "the greatest yet most compact shopping bazaar on earth."

[11] It may seem superfluous to note that also concentrated in this section are almost all of New York's hotels, legitimate theaters, concert halls, first-run movie houses, name night clubs, fine restaurants, etc.

[12] With specific reference to the section's downtown financial district, it has been written: "The tide of humanity that sweeps in every weekday morning, swamping its cramped and crooked streets and surging into its buildings, and then sweeps out again at nightfall leaving almost the whole area enveloped in tomblike silence, is of a magnitude to make the Bay of Fundy's tides seem mere ripples. . . . It is one of the few places in the country where pedestrian traffic jams are worse than vehicular ones." J. Brooks, "Part-time City," *The New Yorker*, Jan. 10, 1959, pp. 76–92.

[13] Approaching the somatic level of reaction, one essayist in a national magazine avows that "this haphazard upthrust panorama is a sight to stir the viscera."

[14] On Midtown's other three sides are a bordering river and two major thoroughfares that set it off from neighboring residential sections with varyingly dissimilar characteristics. By the lines of differentiation marking it off from surrounding districts, Midtown conforms in large degree to the criteria applied by sociologists in identifying "natural areas" within a city.

[15] We resort to a pseudonym for three very different reasons. First, to the residents of the area, who contributed so freely of their time in the interests of the Study, we gave assurances of confidentiality and personal anonymity. Anonymity of locale adds to that word of assurance. Second, it is quite possible that further research may be conducted in the area. To identify the area in these pages could compromise local acceptance of such new programs. Third, there are several place names in local use, but none is applied to the study area with geographical consistency either by residents or by the New York press. Accordingly, the misunderstanding and confusion these available names would certainly promote can be avoided by the new designation here adopted.

[16] From another kind of comprehensive vantage point, the nation can be seen in terms of its large regional divisions, such as New England, the South, and the Far West. For a discerning treatment of the Middle Atlantic states as a region and New York City's place within it, see M. Lerner, *America as a Civilization*, 1957, pp. 202–203.

[17] Adapted from the New York City Department of City Planning *Newsletter*, January, 1958.

[18] As the book goes to press, this record upper limit has been exceeded. Work has begun on Manhattan's tallest residential structure, an apartment house that will rise 35 stories above street level.

[19] Suggestive of recent trend, a City survey in 1958 found that among newly built apartment houses in Manhattan only 5.5% of the units had more than four rooms.

[20] Inquiry would also show, as did the 1950 census, that only 3.3% of Midtown's households own their own dwellings—including quarters in cooperative apartment houses.

[21] It may be of some interest that prior to this date Manhattan had itself been New York City. In that year its name was changed to Borough of Manhattan as part of the consolidation with the other boroughs under the new rubic of Greater New York. However, the legislation that wrote the new names into law could not counteract the force of local attitudes. Thus, residents of all five boroughs, including their bellwether taxi drivers, to this day continue to use "New York" or merely "the City" to refer specifically to Manhattan, a practice long since formally recognized by the U.S. Post Office Department in its local operations.

Behind the persistence of the original usage through the last six decades seems to be a perception that the Island was and remains *the City*, an entity unto itself.

[22] For an evaluation of its influence see L. Mumford, "The Metropolitan Milieu," in Klein, *op. cit.*, pp. 20–31; and D. Wecter, *The Saga of American Society*, 1937.

[23] One of these became Washington Square.

[24] As a result, not a few of the newer buildings in Manhattan's Business Section are the third or fourth structure to occupy their respective sites in a century. Some replaced in the Island's 1950–1959 construction surge were themselves put up during the previous boom of the late 1920s.

[25] With it also moved the theaters, music halls, hotels, hospitals, and, in some instances, churches. However, many of the latter remained on their original sites. Thus, if the extant Protestant churches of denominations associated with the upper class are spotted on a map of Manhattan, they will reveal, in trace outline, the historical course of the northward movement just described.

As a case in point, the Grace Episcopal Church (now on Broadway and 10th Street) recently observed the hundred-and-fiftieth anniversary of its founding. On that occasion, *The New Yorker* recalled that in its original edifice, Grace Church "attracted what newspaper and magazine accounts for a hundred years afterward were to

describe as *'la crème de la crème'* of New York society. Within thirty years, the cream having moved their residence northward, Grace Church decided to move north, too."

An account in the same journal suggests that merchants serving *"la crème"* were more nimble in following their customers. One family dynasty of men's clothiers had a migratory history of 100 years confined entirely to Fifth Avenue. Beginning on 16th Street, this establishment "had a twenty-year stay in that neighborhood, then twenty years at Thirty-Fifth Street, twenty years at Thirty-Ninth Street, twenty years at Forty-Fourth Street, [then] moved to Forty-Ninth Street, where it remained for eighteen years," and today is on 59th Street—and Fifth Avenue still.

[26] Characteristically, the elite of Boston never did follow this example. As an illustration of the general attitudes of this group toward what it regarded as New York's ostentatious use of wealth, there is the anecdote about the Boston dowager who in a tone of resignation commented: "There's no use trying to compare with that New York wealth; all we can do is to be as queer as possible."

[27] This pattern is actively operating to this day. That it may continue in the future to its logical conclusion was recently envisaged by one of the City's leading businessmen. He noted that "the northward march of business [will] move to take over some of Manhattan's best residential areas of today" and that "by the year 2000 we can expect Manhattan's 22 square miles to be entirely occupied by skyscraper offices, other commercial enterprises, and hotels."

[28] Such survival has been bought at a price of perennial embattlement. The *New York Herald Tribune,* Sept. 15, 1959, editorializes: "The casual stroller through Murray Hill on Sunday night might have been a bit startled at the sight of Revolutionary War soldiers out in full uniform, but he might also have gotten the point that the residents are trying once more to protect their neighborhood. This time of course the enemy is not General Howe but Borough President Hulan Jack. . . . Murray Hill is one of New York's fine old neighborhoods, richly steeped in history (as the Revolutionary uniforms should remind us), long an island of repose in the commercial bustle of mid-Manhattan, the sort of neighborhood the city should do all it can to preserve."

[29] C. Tunnard and H. H. Reed, *American Skyline,* 1953, p. 98.

[30] For a vivid pictorial record of this and other aspects of the period, see the monumental volume: J. A. Kouwenhoven, *The Columbia Historical Portrait of New York: An Essay in Graphic History,* 1953.

[31] Kouwenhoven notes, "Into these tenements human beings were packed more densely than anywhere else in the world—London's worst slums and the rabbit warrens of China and India not excepted. The Tenth Ward (Lower East Side) in 1890 averaged 522 people per acre (330,000 gross density per square mile)." *Ibid.,* p. 381.

[32] Of these tenements, however, few are at the extreme depths of Manhattan's most deteriorated slum areas.

[33] In a more general respect, New York has been characterized as a place where "the extremes make up in their bizarre neighborliness the city itself." Alfred Kazin, "Brooklyn Bridge," in Klein, *op, cit.,* p. 154.

[34] It may be remembered that Sidney Kingsley's play and movie *Dead End* had such a Manhattan riverfront setting.

[35] H. Zorbaugh, *The Gold Coast and Slum,* 1929; and W. Firey, *Land Use in Central Boston,* 1947, pp. 87–135.

[36] The pattern of this migrational sequence can be illustrated by three cities. Wealthy families from the smaller centers of New England have resettled in the Beacon Hill section of Boston. Similar families from Middle Western communities have established themselves in the Lake Front section of Chicago's Near North Side. In turn, older families from these gold coast areas of Boston and Chicago have moved and settled themselves in the "elite" sections of Manhattan. A fictional case in point is to be found in John P. Marquand's most durable novel, *The Late George Apley.*

[37] In our white Midtown population at least, the Horatio Alger image of the poor American youngster going to the big city is not corroborated. And the related picture

that such people are drawn in large numbers from the rural areas of America is also not supported. On the contrary, among Midtown's American-born in-migrants, only one in seven has come from a farm or village, whereas almost half are from cities with populations of 100,000 or more.

[38] Foreign migrants to smaller American communities there filled the places of native sons who were migrating to the big cities. Cf. W. L. Warner and L. Srole, *Social Systems of American Ethnic Groups*, 1945, pp. 53–66.

[39] Their proportion in the Midtown population has been steadily dwindling since 1920. And given their advanced age composition, it is likely that by 1960 their representation had fallen close to the 20% level. Writing about the foreign-born groups, a chronicler of the New York scene (Meyer Berger, *The New York Times*, Apr. 29, 1956) has observed that they are getting "thinner and thinner through the years. Assimilation works in its quiet, mysterious ways, and new generations tend to blend into the national weave."

[40] We use immigration primarily as a criterion of derivation from a country with cultural background different from that of America's indigenous Yankee stock. Puerto Ricans are a special case. They are American citizens in their home island, and therefore they are not immigrants in the usual legal sense when they settle in the continental United States. Nonetheless, they are probably as culturally distinctive as, let us say, immigrants from Spain and face the same problems of personal and group adjustment. For our purposes, therefore, they will be classified as one of the ethnic groups.

This is by way of prelude to the observation that in 1950 Puerto Ricans comprised 7.0 and 1.2%, respectively, of the Manhattan and Midtown populations.

[41] Reporting a Fifth Avenue parade of 15,000 marchers celebrating General von Steuben Day—resumed in 1958 after a lapse of forty years—*The New York Times* indicated: "The marchers were described as representing every segment of the German-American community in New York, New Jersey, Connecticut and other neighboring areas."

[42] Cf. Warner and Srole, *op. cit.*, pp. 67–102.

[43] There is no firm evidence on the religious composition of either the Manhattan or New York City populations. However, estimates have been made suggesting that compared to the Midtown sample the over-all representation in Manhattan is approximately the same for Catholics, somewhat smaller for Protestants, and somewhat larger for Jews.

[44] By Census Bureau definition, places with populations of 2,500 or over are urban.

[45] Broken marriages are also relevant here. However, available census publications combine the divorced with the widowed and the separated with the married, and they are therefore of little use for our purpose. As a matter of record, in our Midtown age 20 to 59 sample, the divorced and separated comprise 11.5% of those ever married and the widowed 7.7%. No comparable age specific rates in other populations are available.

[46] In the Chicago studies of that earlier period the usual locus of singleton dwellings were rooming houses, in which tenants lacked private cooking facilities. There is evidence that this was also the case several decades ago in Midtown. But in our study area at the time of writing, rooming houses had in most cases been transformed into utility apartment buildings by the expedient of placing a pullman kitchen in a closet or corner of the one-room dwelling unit. More suitable middle-class variants are to be found in Midtown's residence clubs (usually lacking cooking facilities) for unattached women and in one-and-one-half-room apartments of recent construction.

[47] These are in large part younger people, i.e., under the age of 40. But it might be noted from our own sample of Midtown adults that among women between the ages of 40 and 59 about 19% are unmarried, a rate three times greater than among women of the same age in the national population. As for Midtown males in the 40 to 59 age range, 15% are unmarried, a rate about twice that of men of like age in the nation at large.

[48] It has long been established that urban middle- and upper-class populations are associated with low fertility rates, and families of low socioeconomic status, both urban

and rural, with high fertility rates. It is accordingly striking that when these older Midtown wives are analyzed according to socioeconomic levels, there are no appreciable differences among these levels in the proportions of childless or one-child women. On this particular criterion of fertility, Midtown's low-status women appear to be as infertile as their higher-status neighbors. However, when the former do have more than one child, they tend to have larger numbers than do the women of higher station. In fine, large families are far less prevalent among them than has heretofore been observed but are by no means extinct.

[49] The largest participation by women in the labor force is in the great metropolitan centers. [This] decreases as the size of the city decreases." E. Shevky and M. Williams, *Social Areas of Los Angeles*, 1949, p. 46.

[50] This ratio seems to be contrary to the historical image of immigrants as heavily weighted with males. However, among the 1.3 million immigrants of all ages who entered the United States in the years 1936 to 1950, females outnumbered males by 140 to 100. We estimate that among the adults of this immigrant population the sex ratio approximated 150:100. Thus, the ratio reported here for the foreign-born adults in the Midtown sample may largely reflect the sex composition of immigrants to the United States in recent decades.

[51] Even if an affirmative answer were indicated, the present study, needless to say, would have been amply warranted. The special or extreme case, even if *sui generis*, is worthy of investigation in its own right. In that event, the researcher faces an important disadvantage, in that the generalizations he can draw from the findings are severely limited. On the other side of the scale, such findings may generate hypotheses of potentially large significance for investigations of cases having greater generality.

CHAPTER 6 *Population Distillates*

Leo Srole

In a long-standing characterization, Manhattan residents are reportedly all settlers from somewhere else. This can be read as implying either that conception, gestation, and birth are phenomena too delicate to be elicited or sustained in Manhattan's raucous environment, or that children delivered there are quickly transferred for safekeeping to more antiseptic surroundings. Both inferences, needless to say, are false in the main. The characterization, on the other hand, has a certain large basis in fact. To judge from our cross-section sample of interviewed adults, Midtown's age 20 to 59 population is divided into three more or less equal parts: (1) the immigrants from overseas; (2) the in-migrants "from the lanes and alleys, streets and avenues" of America, as Melville phrased it; (3) the New York City–born. Moreover, one-third of the latter, although "launched" in New York, were raised elsewhere by their *émigré* parents, and therefore, in a strict sense, they also are in-migrants to the City. All told, then, about three in every four of the indicated Midtown population have made the passage from the home town of childhood to an adopted dwelling in the massive, three-dimensional congestion of Manhattan.

From this fact follow two insistent questions: Why did these migrants come to New York City? Why did they settle in Manhattan in particular? [1] Certainly, a common motif behind the act of migrating to New York, whether overland or by sea, lies in the cultural, ideological realm of what has been called the American Dream. In a notable essay on the City, this has been given expression in eloquent form: "[New York] is to the nation what the white church spire is to the village—the visible symbol of aspiration and faith, the white plume saying the way is up." [2]

Economic realities are in part the substance of this symbolic dream role played by New York.[3] Historically, a great metropolis first outpaces competitor cities in population growth by more rapidly expanding its economic accommodation for migrants, then maintains its attractive powers by the larger number and variety of opportunities lodged in the towering size and tempo of its economy.

However, we can be certain that among the vast populations aware of New York's economic largess, only a minute fraction respond by breaking native roots to take the expatriate's lonely road to its gates. When we ask how the migrants differ from their home-town peers who did *not* respond in like fashion, objective factors in New York's economy lose much of their explanatory value. This question is decidedly relevant to the mental health focus of this Study. Yet lack of evidence on the stay-at-home fellows of the migrants leaves the question unanswerable here.

Clues come into reach when we scale the question down to the more modest form: What are the migrants like in their main characteristics? From our sample of Midtown adults, we know that both immigrants and in-migrants predominantly moved to the City when they were at an age ranging from late adolescence to late twenties, i.e., they were young, unmarried people at a fledgling and formative stage of their adult careers. Were they more venturesome, more attuned to the American Dream pointing the way up, than their childhood companions who remained behind or who sought lesser plumes? We do not know. But psychological probabilities suggest that perhaps in some part they were.

Essayist E. B. White[4] seems to support this view: "The residents of Manhattan are to a large extent strangers who have pulled up stakes somewhere and come to town seeking sanctuary or fulfillment or some greater or lesser grail. . . . The City is always full of young worshipful beginners."

Drawing from the literature on New York's in-migrants, we know that they include the "talented who make a vital contribution to New York's primacy [in the arts]. . . . Where else but to New York would the gifted . . . hurry to show their wares?" [5] Joining those of specific talent are the bright who go "out and away [from] the towns and smaller cities of America." [6]

We are told that New York also draws to itself "the restless, the dissatisfied and the ambitious, who have demanded more from life than the circumstances of their birth offered them." [7] The phrase *demanding more from life* than parents had given echoes the American Dream that spurs such people to New York.

This prompting is expressed in other phrasings: "For Americans New York symbolizes 'facing life'; it is considered to be our greatest challenge, it is here that people feel they are testing themselves to the limit." [8]

Another major theme in the literature reveals that in the stream of migrants are those for whom New York is more a haven of escape from the place departed than a city sought for its own rewards. On one level it has been suggested that "if Paris is the perfect setting for a romance, New York is the perfect city in which to get over one, to get over anything." [9] More explicit is the observation that "many of its settlers are probably here merely to escape, not to face, reality . . . although many

persons are here from some excess of spirit (which caused them to break away from their small town), some, too, are here from a deficiency of spirit, who find in New York a protection, or an easy substitution." [10]

On this plane, the City is seen as "a place to hide, to lose or discover oneself, to make a dream wherein you prove that perhaps after all you are not an ugly duckling." [11] The theme of the deviant type among migrants to the city has been elaborated by the pioneer urban sociologist, Robert Park:[12]

> In a small community it is the normal man, the man without eccentricity or genius who seems most likely to succeed. The small community often tolerates eccentricity. The city, on the contrary, may reward it. Neither the criminal, the defective, nor the genius has the same opportunity to develop . . . in a small town that he invariably finds in a great city. In the city many of these divergent types now find a milieu in which, for good or for ill, their dispositions and their talents parturiate and bear fruit.

Developing the point, Park adds:

> Because of the opportunities it offers, particularly to the exceptional and abnormal types of man, a great city tends to . . . lay bare all the human characteristics and traits which are ordinarily obscured and suppressed in small communities.

Thus, migration to the metropolis of "the strong, the weak, and all shades in between" seems to operate as a selective psychosocial process, flattening diversity of personality variation in the small communities which are the population tributaries for the big city, and heightening such diversity in the metropolis that receives these self-chosen young people.[13] If so, to the investigator of mental health the metropolis may expose the range of personality differences characterizing the over-all national scene, in a form both more comprehensive and more concentrated than do the drained-off populations of smaller communities.

Of course, the selection process is by no means ended with the act of migration. Writers on the city from the ranks of the fine arts have revealed that many migrants are polarized, positively or negatively, by the metropolis. For some, it is mistress in an affair of unadulterated love. John Lardner[14] writes: "For myself, I can only hope that the next world . . . I don't care which branch of it . . . provides another . . . such as New York."

The Englishman Alec Waugh[15] could observe: "I recognized when the time came for me to leave [New York] that I had been placed under a very special bondage. For I had come not only to love New York, but to feel that I belonged there, and that is a feeling a man very rarely has. . . ."

With more transparent symbolism, Thomas Wolfe[16] writes of

> . . . the iron-breasted city, [where] one comes closest to the enigma that haunts and curses the whole land. The city is the place where men are con-

stantly seeking to find their door and where they are doomed to wandering forever. Of no place is this more true than of New York. Ridiculously ugly for the most part, one yet remembers it as a place of proud and passionate beauty; the place of everlasting hunger, it is also the place where men feel their lives will gloriously be fulfilled and their hunger fed.

To many, on the other hand, the City is an object of undiluted hate, such as could prompt one nineteenth-century English poet[17] to compose the line "God the first garden made, and the first city Cain."

In counterpoint to Lardner's prayer for the afterlife, it has been observed that "there are some who would say with passion that the only real advantage of living in New York is that all its residents ascend to heaven directly after their deaths, having served their full term in purgatory right on Manhattan island." [18]

Perhaps the ultimate in this attitude was expressed by Frank Lloyd Wright:[19] "Here is a volcanic crater of blind, confused human forces pushing together and grinding upon each other, moved by greed in common exploitation. . . . This mantrap of gigantic dimensions, devouring manhood . . . is as good an example of barbarism as exists."

The literary commentator Alfred Kazin has recently called attention to these polarities in two of America's greatest writers, both native sons of Manhattan and contemporaries. "Herman Melville's *Pierre* . . . is full of downtown New York . . . the landscape of a certain bitterness. . . . The city which Melville usually describes as a dark place to live in and a good place to leave . . . aroused in Walt Whitman every golden hope. . . . For Whitman America began in the streets of New York. . . ." [20]

One explanation for the extreme, enduring dissonance of affect toward the metropolis is suggested by Thomas Wolfe:[21] "The city has a million faces, and . . . no man ever knows just what another means when he tells about the city he sees. For the city that he sees is just the city that he brings with him, that he has within his heart . . . made out of sense but shaped and colored and unalterable from all that he has felt and thought and dreamed about before."

Another element is illuminated in the personal history recorded by John Steinbeck.[22] He delineates four stages in his in-migrant's reactions to New York. First, settlement and retreat: "The city had beaten the pants off me. Whatever it required to get ahead I didn't have. I didn't leave the city in disgust. . . . I left it with the respect plain unadulterated fear gives." Then, brief visits when "I pretended and believed my pretense, that I hated the city and all its smiles and traps . . . and I fled the Whore of Babylon with relief and virtuous satisfaction." Next, reluctant resettlement in a Manhattan apartment: "but even then I kept contact with my prejudices . . . I was going to live in New York but I was going to avoid it. . . ." Finally, sudden conversion: "a kind of mystical experience . . . something burst in my head, a kind of light and a

kind of feeling . . . which if it had spoken would have said, 'My God! I belong here' . . . I was no longer a stranger. I had become a New Yorker!

"Now there may be people who move easily into New York without travail, but most I have talked to about it have had some kind of trial by torture before acceptance."

In the same vein, it has been noted that Manhattan "daunts everyone who comes to it . . . even Americans, perhaps especially Americans. . . . They confront it with some of the emotions recruits feel going to the front, or fliers feel soloing for the first time." [23]

We have earlier suggested that migrants to New York, American and foreign-born, may represent a selective screening from their home populations. But there is also an outbound traffic from the metropolis, consisting of newcomers who were repelled by it, and also of native New Yorkers.

Testimony of highly literate people reveals that migrants to what Sartre has called "the harshest city in the world" undergo a second screening process, arising from the enormously complex depths of individual personality under impact of the enormously complex realities of the City.

As a consequence of this trial, many newcomers find their needs, normal or deviant, fulfilled and fervently adopt New York as their permanent home. Others find their needs and expectations frustrated and, as one writer phrased it, "go down in it, embittered, or flee from it." [24] Still others, in their ambivalence somewhere between the above two types, make a compact with themselves to remain, but with the understanding that it will be temporary. . . . These people have been known to characterize themselves as "carpetbaggers." If they finally leave they can say, as did one of their number: "Once I visited New York for twenty years and I wouldn't live there [again] if you gave me Philadelphia. . . . I'm glad I don't have to cope with New York anymore." [25]

Of those who migrate to New York and sink roots, a further question may be asked: Why do they usually choose to wedge into the overcrowded island that comprises only one-fourteenth of the City's land area? When considering this question it should be recalled that on arrival they are largely young, unmarried people in the early years of forging a career, and are following essentially the same pattern as many natives of the City's other boroughs who move to Manhattan at approximately the same stage of life.

We can infer that by and large their motives for choosing Manhattan are relatively uncomplicated, at least on the surface. First, their careers usually revolve around institutions that are located in or near Manhattan's Central Business Section, and quick transit to and from the job is crucial in budgeting scarce time for the many interests of life. Second, in or near the Business Section are most of the City's wealth of recreational institutions, which uniquely distinguish Manhattan from the home town or

home borough. Third, in Manhattan above all can one find the companionship of peers in age, stage of career, and unmarried status. All of these motives are touched in the advertisements of a new apartment house directed to the "Manhattan Miss" who is a "Quick-change artist. She can go from fashion designer to dazzling date in the shortest possible time because her elegant street suite is mere minutes from her office. And since it's mere minutes from theaters, shows and clubs she can get home early enough on week-day dates." Finally, to young, native New Yorkers from other areas of the metropolis (as to in-migrants), movement to Manhattan is often a decisive declaration of independence from parental controls.

As long as these Manhattan settlers remain single, such motives will almost invariably keep them in the hub borough. If they marry and remain childless, by design or otherwise, more or less the same motives usually continue to operate, probably reinforced if both husband and wife are employed. However, when children begin to arrive, a series of complicated problems come with them.

Around these children has raged a perennial debate that has filled programs of Manhattan parents' organizations and columns of the press. The subject of the debate, variously worded, is the proposition that "Manhattan is no place to bring up a child." Defenders of the metropolis in this controversy have usually built their case on the "stimulus" view that to the child it "holds tremendous intellectual challenge, magic, adventure, and beauty."

The impartial visitor in search of relevant facts may begin on the less romantic plane of the child's immediate surroundings. The New York City Housing Authority, administering over 100,000 low-rent dwelling units in public housing projects, has applied a formula relating family size to size of the dwelling occupied, namely, a limit not exceeding two persons per each dwelling bedroom. With this as a norm, the visitor could inspect the Midtown sample dwellings—all in private housing—that have three or more occupants and should be accommodated with two or more bedrooms. Taking into account socioeconomic level, he would find that 77% of lower-status families lack such housing accommodations. Among households of middle and upper status, the corresponding figures are 64 and 34%, respectively.[26] Because of the exceptionally high cost and sheer numerical scarcity of multibedroom Manhattan dwellings, many Midtown families on all socioeconomic levels cannot provide fully adequate sleeping arrangements for their children.

The waking period of the child's day emerges as a problem of even larger proportions. Small in floor space and catch of sunlight,[27] most Midtown dwellings would hardly impress the observer as sufficient play area for the child in the long age range of self-locomotion. A recent book in the how-to-do-it genre, entitled *Understanding the City Child*[28] and addressed to that child's parents, reveals the situation in the following way:

One thing is certainly safe to say about the average child in the city: he spends more time indoors than does his opposite number in country or suburb. In addition, more of this time is likely to be spent under his parents' feet. The amount of time the apartment dwelling youngster must spend indoors is undoubtedly the greatest drawback to city living. . . . If possible, some indoor arrangement should be devised to give youngsters . . . an opportunity for climbing, hanging by their hands, or otherwise working off accumulated physical steam in an acceptable way.

Nevertheless, children must have outside space for unhampered play and free access to the company of others their age. To this point, the book just quoted strikes another indoor note when it suggests to the city child that "social life can flourish up and down the stair well or elevator shaft of an apartment house as easily as in the backyards of happy memory. Differently, perhaps, but easily." [29]

But the child insists he "wants out." The observer notes in Midtown that an open play area connected with a residential building is a rarity and parks and playgrounds are few, with one exception small and overcrowded, and for most children too distant for ready use. Available, therefore, is only the cement and asphalt street area, consisting of narrow sidewalks and a "nightmarish congestion" of cars, bumper to bumper, both parked and moving.

One pictorial magazine article that celebrated the "glamour" of Manhattan evaluated these elements of the child's environment in an apparently serious vein:

To be a boy in New York is to be free . . . to be a man before you're out of boyhood. . . . Who needs a pasture? [A boy] has a whole street . . . a whole city of streets . . . where he can run about, learning nimbleness by dodging through traffic. Who needs nine men on a ball team? It's a better game with three . . . There's no fat on him, and since he has breathed exhaust fumes all his life, he can endure anywhere. . . . He wouldn't swap New York for all the fresh air in the West.

That this view is less than universal is indicated by the local mother who affirmed that "it's hard on children to be shut away in town." Another Manhattan mother briefly amplified with the explanation, "I can't just let them run out the door to play here." Truman Capote, recalling the metropolis where he grew up, concludes that "for a child it is a joyless place."

There is evidence suggesting that this is a matter of considerable disquiet both to Manhattan parents and the civic conscience. A newspaper account of a PTA conference on "The Urban Child" reported, in part, as follows: "How can city-minded parents 'sell' the city to their young and still avoid the pangs of guilt that stab so sharply when boys and girls complain about urban living?" The article indirectly tries to allay this guilt by observing: "Countless influences from Mark Twain's books to

television's Westerns conspire to convince youngsters that life outside the city limits is one sparkling adventure after another. . . . Under the influence of these subtle 'commercials' for non-city living[30] many a youngster wails long and loud against the fate that keeps him dry-gulched in concrete canyons. . . ."

However, the piece goes on to quote a mother in postmeeting interview who revealingly commented: "We've reached the point where we can take it fine when a four-year-old says 'I hate you!' But let him say 'I hate it here!' and we get all tied up in knots. In the first instance we know that his anger is just part of a passing mood. . . . In the second, we react as if his expression of irritation carried the weight of a Supreme Court decision."

The heavy civic conscience is manifest in the local voluntary organizations which, reminiscent of the legend of the sorcerer's apprentice, try vainly to sweep the children "off the city streets." It is manifest in the newspapers which regularly and waspishly call attention to "the shortage of recreational facilities for our children." It breaks through, sometimes tinged with anguish, in their editorial lapses from civic optimism, such as in the following examples:

1. From an editorial on efforts to plant trees on the streets of Manhattan: "It is interesting to envisage New York turned into a forest. The Indians may yet be persuaded to take it back."
2. From an editorial entitled "Chaos in Microcosm": "The state of disorganization into which this overorganized civilization of ours is falling shows itself in little as well as in big ways. . . . New York City, for example, is probably the most highly developed and complex urban organism in the world. Yet the mechanistic structure we have built is getting to be so intricate that . . . we seem to be losing the art of living with the monster our mechanical and industrial genius has created."
3. From an editorial on financial support for new schools: "Maybe it is a mistake to build cities as vast as this one. But the flesh and blood that goes to school in such cities is essentially just the same as that which long ago walked bare foot to the little red school house."

The issue was also opened to our sample of Midtown adults. Although their views are being held for discussion in a later context, it can be indicated here that they strongly support the proposition that "Manhattan is no place to bring up a child."

Accordingly, on this and other evidence, limitations of the Manhattan environment for the child's well-being are judged to be both objectively and subjectively real. We can assume that if this were the only consideration pressing upon parents there would be a nearly complete exodus from Manhattan and Midtown of couples with children. Indeed, for many decades, but in particular since 1946, one of the best-publicized social "movements" of our time has been the evacuation of an estimated 12

million American families from metropolitan centers to the suburbs and exurbs.[31] The prominence of children among these exmetropolites is one of the most striking aspects of the movement.[32] The magnitude of this movement locally is indicated by the report of the New York City Board of Education that in the years 1951–1956 about 210,000 pupils, equivalent to one-fourth of the total 1951 public system registration, transferred to out-of-city schools.[33] Nevertheless, that about one-half (47%) of all married people in our Midtown sample have one or more children under the age of 18 documents the degree to which this exodus has been considerably less than complete.

It can plausibly be assumed that these Midtown parents are different, in certain respects, from those who departed. For the latter, it seems clear, the well-being of their children was a dominant motive for making the considerable change in environment. Although the interests of their children were doubtless no less weighty to the parents resisting the pressures for removal to suburbia, we must assume that other, stronger values took precedence in keeping them anchored in the Midtown area. It is not possible, nor altogether necessary here, to explore these other values systematically. However, it is possible, at least inferentially, to discern a common thread carried over from the central motive that brought these people to Manhattan in the first place, namely, an overriding commitment to the way up, or the "glory road" that runs through the Central Business Section.

In the case of the white-collar Midtowner, there are a number of indicators pointing in this direction. For example, economically they "travel light" by severely restricting the number of children they produce. By employment of the wife, in many cases, they increase family income. Moreover, from the writings of middle-class Manhattanites we cull characterizations of the Island as a place "geared to adult ambitions," and tailored "for the type of people with get-ahead-or-else drives."

That the City is the natural habitat of this type of individual is revealed in an official brochure[34] where he is baited with

> . . . that subtle, pervading, and often determining factor: *being in the swim!* To be associated with success; to rub elbows with the pace-setters; to be so close to sources as to get the latest ideas by word of mouth; to look around and *see* that you are shoulder to shoulder with competition, if not ahead of it —these are privileges that go with a New York location and automatically confer CONFIDENCE and spell PRESTIGE.

Above all, there seems to be reflected the need to mobilize leisure time and social relationships around "the job." To this end we are told, each by a separate writer, that it is necessary (1) "to do the right thing with the right people in the right places," (2) "to keep in touch socially with old business friends and new business contacts," (3) "to work harder

and hustle more than anybody else," (4) "to keep on top of the whole picture by collecting information all day long."

As capstone we have the testimony of a rising business executive known to us who had lived in Midtown, moved to the suburbs, and before long returned to Midtown. Explaining the return: "The headquarters of my firm are here. If I am to go to the top Manhattan is where I should be—to entertain business associates and customers." A returnee wife has said: "My husband was so busy that *if I wanted to see him* I had to live in town."

Here we seem to see the mandate of the American Dream carried to its farthest point of development, in which one's leisure, comfort, cronies, wife, and children are transcended in a sense by the higher value placed upon the climb to the top, or at least to the ever-present next rung. Apparently, residential proximity to the Central Business Section is inescapable because one's home and private life have in effect become annexes to one's office.

If these people appear to fit certain specifications of the "organization man" as drawn by W. H. Whyte, Jr., surely the resemblance is no mere coincidence. Whyte, however, tracked his man to a family house in the suburbs and almost completely overlooked his psychosocial "twin" in the skyscraping apartment buildings of Manhattan.[35]

The precise line dividing such Midtowners from their suburban twins is suggested by the comment of one of the latter that "I'm anchored to my office but that's no reason my family should be near it."

There is little in the available literature to indicate whether a comparable orientation exists among Manhattan people who are in the blue-collar occupations. Although these are probably not mobilized in their get-ahead drives as are their white-collar neighbors, there are intimations from our Midtown sample that such aspirations are by no means absent. For example, we earlier noted that a surprising number of such couples have only one child or none, the middle-class pattern of "traveling light" (in number of offspring) for the upward climb. Also, many of these wives are employed, suggesting diversion of their domestic roles for enhancement of family income toward the middle-class range. During their work histories, far from remaining frozen in one occupation, these men have shifted their line of work to about the same considerable extent as have the middle-class males. Finally, on a question relating to "worries about getting ahead," as large a majority of the blue-collar men expressed such a concern as did the white-collar males.

Thus, if these working-class families are different, in ways we cannot specify, from their peers who left the crowded Midtown tenements for more open sections of the City and its suburbs, they appear, in respect to certain basic values, not unlike the neighboring higher-status families

who for certain ends have also elected to remain within the cramped confines of Midtown.

Amid the great socioeconomic differences we can discern a common core of values by which a Manhattan residence is often a means to *future* goals, rather than that key *current* end: adequate family *lebensraum.* Pressing upon us from the observation just made were these questions: How do its people actually regard Manhattan as a human habitat? Will we find here the predominant tendency to consider one's community at the very least "as good to live in as any other place"? [36]

The issue was put to our sample of interviewed Midtown adults in several different ways. One query asked the respondent: "For *yourself,* do you think it is better to live on a farm, in a small town, in a small city, or in a big city like New York?" By their replies 53% of the sample indicated their feeling that they would be better off living elsewhere than the big city they now occupy.

This interview item was preceded by two more pointed inquiries. One, asked much earlier in the interview session, offered health effects as a criterion for assessing the local environment. Here respondents could react to the opinion that "the big city is just as healthy to live in as any other place." A total of 57% flatly disagreed with the proposition.

Applying a third criterion, immediately preceding the "for yourself" item the respondent was asked: "For *growing children,* do you think it is better to be brought up on a farm, in a small town, in a small city, or in a big city like New York?"

In reply, 85% of the sample respondents with varying degrees of intensity recommended any place other than a big city like New York as a place for raising children. Of course, we expected that these particular replies would vary decisively with the rural-urban backgrounds of respondents. This proved not to be the case. Native New Yorkers were as overwhelmingly disapproving of their city in this respect as were the immigrants and in-migrants from smaller home towns.[37]

Let us now classify respondents according to the major combinations of their replies to the two questions soliciting perceptions of the metropolis as a home setting for themselves and for children. Exactly half of the sample population were consistent in rejecting Manhattan, on both counts, in favor of other alternatives. Doubtless some of these are of the "carpetbagger" type, long-term transients who look forward to ultimate breaking of the chains of career that keep them anchored to Manhattan. Some are parents of young children and are likely candidates for suburbia.[38] Others are probably the defeated and embittered who are too encumbered to take the course of flight.

Another 13% of the sample adults were consistent in upholding the metropolis on both counts in preference to other alternatives. These are probably the people who see Manhattan as the best of all possible worlds,

avow they would live nowhere else, and emphasize, as did George M. Cohan, that "When you're away from Broadway, you're only camping out," or, as did "Bugs" Baer, that "any other big city is Bridgeport to me." On the same point, Theodore Dreiser[39] quotes an old, "half-demented" Manhattan seamstress and slum dweller to the resolute effect that "I would rather live in my [single] hall-bedroom in New York than in any fifteen-room house in the country that I ever saw!"

With characteristic flourish, Alexander Woollcott[40] writes: "Since God lifted this continent above the waters and so clad its plains and valleys that it could be a homestead for a numberless multitude, it must fill Him at times with mingled surprise, amusement and exasperation to note how many of us are perversely scrounged together in a monstrous determination to live crowded on Manhattan Island and there only—there or not at all."

Perhaps most interesting of all in our Midtown sample population is the 37% segment that revealed mixed feelings of one pattern or other by rejecting the metropolis as the milieu of choice for growing children, but approving it for themselves despite its acknowledged shortcomings.[41] The literature gives ample voice to this kind of orientation in its many variants.

Relevant is the following excerpt from E. B. White's memorable essay:[42]

> By rights New York should have destroyed itself long ago, from panic or fire or rioting or failure of some vital supply line. . . . New Yorkers meet confusion and congestion with patience and grit—a sort of perpetual muddling through. Every facility is inadequate—the hospitals and schools and playgrounds are overcrowded . . . there is not enough air and not enough light. . . . But the city makes up for its hazards and deficiencies by supplying its citizens with massive doses of a supplementary vitamin—the sense of belonging to something unique, cosmopolitan, mighty and unparalleled. . . . The city is uncomfortable and inconvenient, but New Yorkers temperamentally do not crave comfort and convenience—if they did they would live elsewhere.

Steinbeck[43] elaborates the theme:

> New York is an ugly city, a dirty city, its climate is a scandal, its politics are used to frighten children, its traffic is madness, its competition is murderous. But there is one thing about it—once you have lived in New York and it has become your home, no place else is good enough. All of everything is concentrated here. . . . It is tireless and its air is charged with energy. . . . Every once in a while we go away for several months and we always come back with a "Thank God I'm home" feeling. For New York is the world with every vice and blemish and beauty. . . . What more could you ask?

A more clear-cut stage of unreconciled conflict may be discerned in the book *Manhattan and Me*[44] by Oriana Atkinson, who is a Manhattanite. To cite a series of relevant comments in their actual sequence:

Walking about the streets and observing the state of dwelling houses in general, you get the uncomfortable feeling that this is a doomed city [page 28].

New York is no place to live, no place to bring up a child. So people say; so many New Yorkers admit [page 39].

What would be the answer from all the young who inhabit this mammoth cave? . . . I think I know without asking. Everything I have said about this vexatious city is true. And yet everything I have told you is a lie. . . . New York [is] the city whose ultimate boon is youthfulness of spirit. . . . I knew, deeply, that New Yorkers are really a happy people. . . . We [New Yorkers] are a young and vigorous race, geared to excitement, contradictory, emotional, ready for whatever the next hour may bring [pages 41–42].

It seems like a dismal shame that a city like this one, with everything in the world necessary for the health, happiness, and general welfare of its citizens, should have degenerated into such a slovenly, mean, uncomfortable place to be [page 132].

It has been said, and perhaps with truth, that anyone who has ever lived in New York cannot be happy living anywhere else. Speaking for myself, I know I'm very tired of this city; yet, when I think over the other places where I might choose to end my days, I am always doubtful that I'd be happy there [pages 265–266].

Whether they perceive Manhattan's blemishes or not, whether they affirm or deny it as an adequate place to live, most schools of thought testify to the Island's "youthful spirit," "excitement," and "exhilaration." We approach here an intangible, elusive quality of the metropolis, that seems to elicit in its residents a heightened sense of vitality. Although self-consuming, this brand of *élan* persuades that one's life energies burn brighter and higher while it lasts. Such seeming surcharge of personal energy, vistas of the steep but open way up, proximity to the arena of career battles, and immediate access to a huge array of recreational facilities, together, we infer, bind to Manhattan people who in the strict logic of family comfort and well-being would otherwise settle, as one ex-metropolite deftly put it, "for the airier way to live."

To recapitulate, then, the population of Midtown, like that of Manhattan, is the distillate of a three-stage process of selection. First, from the large American and foreign populations there is selection of the few, relatively speaking, who leave their childhood homestead to build new lives in the vastly different environment of New York City. From all these, and also from people native to other parts of the metropolis, there is a screening out, in the second stage, of those who elect to reside in a Manhattan section like Midtown. Finally, from those who settle in Manhattan there is a winnowing of those who elect to remain, when the best interests of self and family urge removal to more spacious sections of the metropolitan region.

After the centennial of Charles Darwin's revolutionary book, it may be relevant to recall his emphasis on the process of biological selection in the

evolution of species, as each adapted to the environment and its changes. By way of rough analogy, there are discernible in Midtown processes of psychosocial selection. From vastly diverse human populations these processes operate to draw individuals into the highly specialized cliff-dweller habitat of the great city.

And we suggest that the Midtown population, for all its great heterogeneity, can be viewed as an emergent of a relatively new, localized species of American. This is the species that is adapted, albeit in an uneasy fashion, to its chosen environment at the vortex of the one city to have been saluted as "the world's supreme metropolis."

FOOTNOTES

[1] Given the extreme length of the Home Survey interview, evidence bearing on these particular questions could not be secured from our sample adults. However, other kinds of testimony are available to us.

[2] E. B. White, *Here Is New York*, 1949, p. 23.

[3] There are specific limiting sides to these realities, as are revealed in two facts. When New York's economy was expanding in its "heavy work" sectors both immigrants and in-migrants were predominantly males. When, as in recent decades, these sectors contracted and growth shifted to the "paper work" functions, the sex balance shifted toward females among both types of migrants.

[4] White, *op. cit.*, pp. 9 and 32.

[5] H. Taubman, *The New York Times Magazine*, Apr. 29, 1956.

[6] Granville Hicks, *Small Town*, 1946, p. 25.

[7] Alec Waugh, *The New York Times Magazine*, Apr. 29, 1956.

[8] Editors, *Holiday*, October, 1959, p. 49.

[9] Cyril Connolly, *Ideas and Places*, 1959, p. 176.

[10] White, *op. cit.*, pp. 16 and 17.

[11] Truman Capote, *Local Color*, 1946, pp. 13–14.

[12] Robert E. Park, *The City*, 1925, pp. 1–46.

[13] Grayson Kirk has observed of New York that "here in almost complete cross-section are representations of virtually every social, racial and economic problem America knows." (*The New York Times*, Apr. 26, 1956.) To this roster of problems can probably be added those in the realm of personality.

[14] John Lardner, "The Case for Living Here," *The New York Times Magazine*, Apr. 29, 1956.

[15] Waugh, *op. cit.*

[16] Thomas Wolfe, *The Web and the Rock*, 1939, p. 229.

[17] Abraham Cowley, "The Garden."

[18] A. Klein (ed.), *The Empire City*, 1955, p. xxi.

[19] Frank Lloyd Wright, *The Disappearing City*, 1932, pp. 435–436.

[20] Alfred Kazin, "Writing: The Voice of the City," *Holiday*, October, 1959, pp. 88–89.

[21] Wolfe, *op. cit.*, p. 223.

[22] John Steinbeck, "The Making of a New Yorker," *The New York Times Magazine*, Feb. 1, 1953.

[23] Editors, *Holiday*, October, 1959, p. 49.

[24] Meyer Berger, "Preface," in Klein, *op. cit.*, p. xx.

[25] Frank Sullivan, "The Case for Just Visiting," *The New York Times Magazine*, Apr. 29, 1956.

[26] A newspaper article reports a Manhattan luxury-housing survey to the effect that "high income, high-rent tenants spend their shelter dollars not on added space but on quality and location." On the other hand, a critic of Manhattan's recent resi-

dential construction observes as a trend that "luxury apartments become smaller, shoddier and more stereotyped."

[27] One critic arraigns the skyscraper that "has destroyed light, space and air, and turned sunshine into a special privilege."

[28] Dorothy Barclay, *Understanding the City Child*, 1959, pp. 50, 56, and 150.

[29] *Ibid.*, p. 150.

[30] With remarkable prescience, Mark Twain put this warning notice at the head of *The Adventures of Huckleberry Finn*: "Persons attempting to find a motive in this narrative will be prosecuted . . . persons attempting to find a plot in it will be shot."

[31] To one local journalist, "the greatest migration since the days of the covered wagon."

[32] "The exurbs and all exurban life are primarily centered around the children. A couple may have had all sorts of bemused reasons for moving so far from the city, but the wife had one compelling one: her children are out of the city. . . ." A. C. Spectorsky, *The Exurbanites*, 1955, p. 248.

Referring to critics of the city-to-suburb movement, one ex-Manhattan mother wrote in a letter to the editor: "[Have they] stopped to consider that parents who made the change from city to country were not necessarily seeking 'Suburbia.' The real reason for moving was the desire for freedom from a confined city apartment . . . the houses beckoned and the people went."

[33] Further, a study by the New York Regional Plan Association reveals that these departing families are being replaced predominantly by one- or two-person households.

[34] *What's So Big about New York?* New York City Department of Commerce and Public Events, undated.

[35] Furthermore, we do not view the Manhattan variant of the "climbing man" type as specific to rising executives but as covering more or less the entire range of white-collar jobs, both in corporations and out. Thus, Whyte's model of the organization man appears to be a subtype of the climber species. W. H. Whyte, Jr., *The Organization Man*, 1956.

[36] A. Kornhauser, *Detroit as the People See It*, 1952, pp. 5–18.

[37] Least approving were the childless group of never-married and married-but-infertile respondents (10.7%), as compared with the parent group (19.5%).

[38] In fact, about 30% of the entire sample indicated they have thought of moving out of "this section of town."

[39] Theodore Dreiser, "The City of My Dreams," in Klein, *op. cit.*, p. 413.

[40] Alexander Woollcott, "No Yesterdays," in Klein, *op. cit.*, p. 420.

[41] Stated differently, of all respondents who said they regarded the big city as the best place for themselves, only 24% expressed the opinion that it is similarly suitable for the young. Focusing on the good-for-me group exclusively, we find that good-for-children replies were given by 37% of the low socioeconomic stratum in the group, 28% of the middle stratum, and 17% of the upper.

On the surface, these data appear somewhat surprising. Of course, the financial resources of the high-status people are translated for the child into larger living quarters, domestic help to expand mother's free time, private schools, special recreational advantages, etc. On the other hand, the lower-SES adults see their children without any of these buffers to the metropolitan environment. Accordingly, we could expect the high group to be more prone than the low to favor the big city as a home base for the young.

That the reverse is the case, among those apparently committed to Manhattan for themselves, suggests the following as one possibility: The upper-SES group, predominantly also of higher education, may be more critically aware of and concerned about the potential impact of the metropolitan milieu as it bears, *even at its very best*, on their children.

[42] White, *op. cit.*, pp. 24–26 and 50.

[43] Steinbeck, *op. cit.*

[44] Oriana Atkinson, 1954.

CHAPTER 7 *Community Institutions and Psychosocial Climate*

Leo Srole

"A house," in the professional accent of Mme. Polly Adler, "is not a home." On the same principle, a metropolitan area and its people do not necessarily make a community, as Manhattan's Bowery district and its flophouse tenants need hardly testify.

How far Midtown warrants accreditation as a full-fledged community or falls short of that estate is one of several questions to be considered in this chapter. The issue is entangled in complexities that require a more extensive use of conceptual instruments than has been necessary hitherto in the present part of this book. Moreover, we move here on ground where our literary witnesses, so illuminating in the preceding chapter, are decidedly less articulate.

To avoid possible misunderstandings of our key concepts, let us fix as one working definition that a population occupying a circumscribed locale is a community to the extent that it satisfies this major criterion among others: The full variety of its human needs—both common and special—are adequately met by ongoing social arrangements, such as have been established in the gamut of extrafamilial institutions. *Institution,* in turn, is here treated as a generic term[1] referring to more or less enduring organizations that, within the communal division of social labor, have specialized functions and specialized personnel, e.g., church, corporation, hospital, and school.[2]

Of course, for a residential section of a city the criterion of human needs locally served cannot apply as strictly as it does to the far more self-contained and self-sufficient entity of the city itself. Nevertheless, our interest here is in discerning the extent to which Midtown is institutionally organized relative to its own needs, problems, and capabilities. Furthermore, this goal is itself only a means to our larger purpose, namely, that of conveying to the reader a sense of the general nature and texture of the human environment in which the people of Midtown carry on a considerable portion of their daily lives. A case study of a

population that omits delineation of the communal aspects of the environment is in a sense as incomplete as a case study of a patient that overlooks his familial environment. With this observation, we would emphasize again the limitations of the present group portrayal made from the birds-eye view rather than from a close-up vantage point.

INSTITUTIONS: TYPES

For descriptive convenience, we might start on the most elementary level of services performed by Midtown's economic institutions. It must be indicated, parenthetically, that the area is free of industrial establishments, except for a few small factories in loft buildings at scattered points near its borders. Thus, its internal economy consists almost entirely of small retail shops and service enterprises in considerable number and variety. Some of these, highly specialized in kind, draw customers from surrounding Manhattan and from other boroughs. In largest numbers, however, they serve either their immediately adjoining neighborhood alone or get the trade of residents from other parts of the Midtown area. Retail stores of the latter type are particularly concentrated along the length of one of the major thoroughfares, which is locally regarded as something of a "Main Street" shopping center.

Despite the proximity of Manhattan's Central Business Section and its unparalleled shopping facilities, to an important degree Midtown residents satisfy their consumer and service wants within local establishments, many of which are long-settled fixtures of the scene. Indeed, the latter and the relatively few inroads of national retail chains, so conspicuous in smaller cities, contribute to the over-all impression of rooted stability in this sector of Midtown's economy.

Turning to the field of professional services, we might compare Midtown with the rest of Manhattan on the yardstick of number or rate of professionals per 100,000 population. For example, Midtown and Manhattan are almost identical in their rates of locally practicing dentists, chiropractors, and morticians. However, a striking divergence is encountered in the medical profession. In 1953, practicing physicians with offices in or overlooking Midtown numbered 1,180 per 100,000 local population, as compared with rates in the rest of Manhattan and the entire United States of 285 and 132 per 100,000, respectively. Midtown's unprecedented rate reflects the fact that the area is a base for heavy concentration of medical specialists serving not only Manhattan and the City at large, but the entire metropolitan region and, occasionally, beyond. As a highly relevant example, we might focus on the psychiatrists among these physicians. Those who were members of the American Psychiatric Association in 1953 and had offices in or adjoining Midtown numbered about 250 per 100,000 of the local population, as compared with corresponding

rates for the rest of Manhattan and for the City's other four boroughs of 18 and 16, respectively.

In many American metropolitan centers, privately practicing medical specialists (like specializing lawyers) predominantly tend to establish their offices within the central business district. It is not relevant here to explore the particular factors that might explain why a residential area like Midtown, rather than Manhattan's main business hub, has acquired this centralized service function. It is pertinent to note one corollary, namely, the fact that Midtown is also a center for hospital institutions, voluntary (i.e., nonprofit), municipal, and proprietary—general as well as specialized. In 1953 these hospitals were 18 in number,[3] and all told provided over 2,100 beds per 100,000 Midtown population, as against 1,100 and 990 beds per 100,000 in the rest of Manhattan and the United States, respectively. Also operating were 25 other medical research and service organizations. It might be added that Midtown exhibits the pattern, seen in other big cities, of major medical institutions congregating in residential areas that adjoin the central business section. Of course, Midtown is only one of a series of Manhattan areas with such concentrations of hospitals.

Two further points about these medical institutions should be noted. First, the largest ones, accounting for most of the beds, are not local in geographical range of their reputations, their supporting funds, or their patients—who come not only from Midtown and the entire metropolitan region but in some instances from the country at large and even from abroad. These hospitals did not spring into being at the initiative of the Midtown community acting out of felt local needs. In most instances they had long been established elsewhere in the City and had "migrated" to Midtown because of their own internal growth and external ecological forces that pressed for a more central and accessible location.

Nonetheless, at-hand availability of medical services in a locality is often a decisive factor in their utilization when need arises or looms on the horizon. Accordingly, in number and quality of hospitals, as in private specialists, Midtown appears to be one of the best-equipped residential areas, medically speaking, in the world.

Also worthy of emphasis is a second fact, indicated in a 1958 report by the Hospital Council of Greater New York. It was there noted about the City's over-all hospital system: "Because hospital care in this city is characterized by a liberal tradition of free or part-pay care, tax funds and philanthropy account for a larger fraction of total expenditures for hospital care in New York City than in the rest of the country." That is, for those without the necessary means, hospitalization costs to an uncommon degree are subsidized by other sources of funds, public and private. This, of course, adds another favorable element to the picture of medical resources within local reach of Midtown residents.

Out of our specific mental health interest, it should also be added that in 1953 Manhattan had 90 psychiatric out-patient clinics, large and small. Although few of these low-fee facilities are in Midtown proper, its residents are within relatively easy transit access to many of them.[4]

All told, in terms of creature, medical, and specifically psychiatric needs, Midtown gives the appearance of being institutionally well served. This appearance, in its psychiatric aspects, is a matter to which we shall return in the next chapter. Now we might proceed further into the larger, encompassing framework of Midtown institutions.

There are a variety of human needs that can be met in a democratic society only by the voluntary, collaborative action of local citizens working through the instruments of their own self-created and self-supported organizations. These fall into two major types: organizations created by and for one of the several constituent groups or segments of the local population, and those established to serve the overarching, common, or general welfare of the entire population. For purposes of convenience we shall designate these two categories of institutions as *segmental* and *central,* respectively.

Perhaps the most conspicuous of Midtown's segmental organizations are its many institutions of worship, including over 30 Protestant churches (predominantly Episcopal, Presbyterian, Baptist, Lutheran, and Methodist), approximately 15 Catholic parishes, a number of synagogues representing the Orthodox, Conservative, and Reform wings of Judaism, and several Eastern Orthodox churches.[5] In size of congregation these vary considerably, among the Protestant churches, for example, in a range from under 100 to well over 2,000. However, there are reasons to believe on the one hand that the parishioners of the Catholic churches are almost exclusively Midtowners, and on the other that the Protestant and Jewish congregations include not a few ex-residents of the area.

Of course, neither the number of institutions of worship nor the absolute number of their local adherents give any clue to the vitality of institutional participation in the population at large. For such a clue we can look to the sample of Midtown adults interviewed for our Home Survey. Among them, slightly less than one-half (45%) report attending religious services more than the gestural three times a year. About one-fourth go infrequently (i.e., two or three times a year); and approximately 30% indicate they never or rarely attend. Thus, hardly one-half of the adult Midtown population can be regarded as having more than a nominal identification with an institution of worship. On the other hand, it must be emphasized that these institutions have gone far beyond their central function of providing for religious worship. Indeed, they are also serving adherents of their own faith through a large and complex network of auxiliary institutions.

Segmental institutions, religious or otherwise, which have adult mem-

bership bodies can be further differentiated according to the major kind of function they perform: (1) the "self-service" function, i.e., the organization serves the needs of its own face-to-face membership; and (2) the "serve-others" function, i.e., the institution is primarily dedicated to the needs of nonmembers, although usually within the same segmental group.[6]

A church or synagogue is primarily a self-service institution in that it is directed to the religious needs of its congregants. However, in the many auxiliary institutions created by the Midtown churches and synagogues, or by their parent bodies, we see in conspicuous form the serve-others motive. These creations include not only systems of day schools, to be reviewed below, but also the following: nurseries for very young children; homes for the orphaned, the handicapped, the aged; recreation centers and associations for adolescents and young people; residence "clubs" for young adults away from home; and adult-education programs. Finally, for its adult members each congregation or parish is sponsor and guide of a series of laity associations that have both self-service and serve-others functions.

Another important source of segmental institutions in Midtown is its large group of high-income residents. Although Midtown has a number of institutions of worship with upper-status congregations, from our Home Survey sample of adults it appears that attendance of religious services, within each major denomination, tends to be inversely correlated with socioeconomic standing. The higher the status, that is, the less frequent is participation and affiliation. It seems, therefore, that the social activity of Midtown's upper-status group revolves predominantly around its characteristic secular clubs and organizations,[7] including separate associations of descendants of Dutch and English "old families." Some of these have quite limited self-service functions, as in the case of the street associations, each created for cooperative planting and maintenance of trees on one or more block fronts of town-house residences. Many organizations appear to combine a primary self-service function of get-together recreation and an incidental serve-others function of contributing to one of a large variety of philanthropies. For other organizations, on the other hand, the dominant emphasis is on supporting a specific service agency or program, local, city-wide, national, or overseas, and social affairs are basically part of the fund-raising strategy. Among the Midtown nonsectarian, serve-others agencies so supported are its voluntary hospitals, its several long-established and professionally staffed settlement houses in tenement neighborhoods, and a number of limited programs and organizations directed, for example, to getting the youth of such neighborhoods off the local streets.

Except for church auxiliaries the middle-class associations, so active and vocal on the social landscape of smaller American communities, in

Midtown appear conspicuous by their scarcity, quietism, and primarily self-service orientations. They include a chamber of commerce, a Lions Club, several geographically limited businessmen's associations, a few posts of the major national veterans' organizations, a number of neighborhood political clubs affiliated with one or another of the political parties, the PTA's of public elementary schools, a League of Women Voters, and a chapter of Alcoholics Anonymous.

The working-class segment of Midtown for the most part is divided into a number of ethnic groups. As we have noted, certain churches serving this particular segment tend to follow national-origin lines of division. Although for some people in these ethnic groups primary participation centers on the church and its auxiliary organizations, for others it revolves around the group's secular associations that are largely recreational in their activities.[8] The latter appear in a variety of special-interest forms. Some carry the word *literary* or *democratic* or *independent political* after the national designation in their titles. Others refer to themselves as gymnastic, athletic, or singing societies.

The smaller of Midtown's major ethnic groups have no local associations of their own in the area but have nationality organizations available elsewhere in the City. On the other hand, several groups have two or more locally based, secular recreational associations that also attract members from other sections of the City. In each of three of these groups there is also a local community hall that is the focus of much of its organized recreational activity.

Conspicuous as these secular associations may be to the observer, the test of the range of group participation is as relevant to them as to the churches. Interviewing our sample of Midtown adults, we asked individuals with ethnic backgrounds whether they had "any interest at all" in the recreational organizations of their particular nationality group. Responding affirmatively were 24% of the immigrant (first) generation, and 10% of the second generation. *Participating* to any degree in meetings or social affairs of such organizations, whether as members or not, were 18% and 6% in the first and second generations, respectively.

Of course, there are wide differences among the Midtown ethnic groups on indices of adult interest and participation in their secular associations. However, in none have we found participants representing more than a minority of the group's adult element.

In this review of Midtown's institutional aspects as a community, we can hardly overlook its schools. The area has three separate educational "systems" each covering the entire span from the nursery level through colleges granting the bachelor degree. We shall not touch upon the latter, nor upon the many high schools (which are of both the college preparatory and vocational types) because in all three systems their student bodies are drawn from Manhattan or New York City at

large. As for the elementary schools, serving Midtown almost exclusively, there are 12 in the public system (16 in 1938), 10 in the Catholic system (as well as several Protestant and Jewish parochial schools), and 20 "private," nonsectarian schools for children of high-income families (16 in 1938).[9] The trichotomy of public, parochial, and private schools highlights for us in summary fashion the institutional segmentation of Midtown along the cross-cutting lines of socioeconomic and religious differentiation. This follows the general pattern of all large, heterogeneous American cities, a pattern deeply rooted in the fundamental democratic rights of freedom of worship and freedom of association.

INSTITUTIONS: CENTRAL

As has often been emphasized, the other side of the coin of democratic freedoms that support group segmentation is the citizen's share in the general welfare, in the community as a common enterprise, and more specifically in those local conditions that are beyond the capacities and authority of the separate segmented groups to resolve. The responsibility that adheres to this share of course transcends individual commitments to a segmental group and its institutions and can only be discharged through what we call central institutions. These are of two main types. One is to be seen as prototype in the voluntary citizens' council, which we shall discuss below. The other appears in the City's overarching municipal government, which for Midtown performs certain "housekeeping" functions, like providing water supply and police, fire, and sanitation services. Of course, it also administers the local public schools. And its departments of health and hospitals maintain special institutions in the Study area.

Not yet given due mention is the City's Welfare Department. Under economic conditions of full employment, as in the Study period, this department primarily extends public aid to three main categories of nonemployable people, namely, children, the aged, and the disabled. For the City as a whole we know that in 1954 over 300,000 individuals were given help to an aggregate of about 220 million dollars.[10] This figures to an average of approximately $700 annually per person. If such assistance per individual is hardly sufficient to banish poverty beneath the roofs of the City, it does put a partially supportive floor of sorts under those without the capacity for self-support.

This particular function of government as a central institution, and a rather controversial one for some local newspapers, must be seen in conjunction with the City's complicated apparatus of social-service agencies that were established by the voluntary, i.e., segmental, type of institutions previously discussed. If one carefully examines the biennial *Directory of Social and Health Agencies of New York City*[11] he

will find many hundreds of social agencies identified and grouped under such headings as Adoption, Correctional Care, Employment and Vocational Guidance, Family Service, Homeless and Unattached, Recreation, and Shelters: Temporary, for Children.

Confronting the City's governmental and voluntary institutions functioning in this field of *special* human needs, one magazine writer declared that "the picture emerges of a huge welfare and eleemosynary setup—one of the largest ever known to man."

Even if this setup were the very largest in history, its sheer size is an uncertain quantity against the question of its adequacy, i.e., its capacity relative to the magnitude of urgent needs to be met in the population it serves. First, in the interest of brevity let us circumscribe the question by arbitrarily limiting ourselves to the needs of children in certain critical circumstances. Then, let us attend the measured words of a state authority in the welfare field, speaking with specific reference to foster care of children who are the debris of irreparably shattered families:[12]

> I think everyone is agreed that New York City faces a critical situation with respect to the care of such children. . . . The voluntary agencies are putting forth their best efforts but the size of the problem is greater than the current facilities and resources to deal with it. . . . A large area of unmet need remains and unless some positive steps to reverse this trend are made, the gap will continue to widen. I think the time has arrived when all the forces interested in the welfare of children should subscribe to an unequivocal policy that no child accepted as a public charge by the [City's] Department of Welfare should be denied care, of the kind needed and when needed, because of any limitation in the facilities or policies of voluntary child-caring agencies.

The last sentence cited suggests the nature of a service failure in unmistakable terms.

Focusing down to a second group of New York children, namely, juvenile delinquents, we read the following query in a New York newspaper: "No other city can boast of police forces more numerous, corrective institutions so progressive and such a structure of municipal, state, Federal and private services dealing with almost every social problem known to man. Why then are juvenile delinquency and the phenomena associated with it measurably on the increase in New York?"

As if in reply to this question, John Dollard, writing in the same newspaper, has commented on New York's delinquency problem: "The main trouble is that there is not enough of anything: institutions, social workers, religious workers, probation officers, settlement house staffs, psychiatrists, teachers, judges, police. . . . The heroic few now working are solving the problem in principle, but they cannot contend with it in fact."

A newspaper article discussed the understaffed Juvenile Aid Bureau

in the City's Police Department and noted that this bureau, with jurisdiction for wayward youths under the age of 16, continues its unwanted "social work function only because there is a vacuum—the private agencies won't take most of these [young delinquents] and there is no public agency equipped to deal with them." For delinquent adolescents over the age of 15 the vacuum seemingly is total.

In its Declaration on the Rights of the Child, the United Nations has codified the universal principle that "mankind owes to the child the best it has to give." It seems, however, that two categories of New York children, both in catastrophic predicaments, are rather beyond the combined management capacities of the sprawling municipal welfare and service apparatus and the multitude of voluntary social agencies. Against this city-wide background of partial default in meeting the crises of the homeless and the delinquent children, we can now return to Midtown for further consideration of its particular effectiveness as a community in serving certain special local needs. For this purpose, we shall first place in evidence the indicators provided by a series of human pathologies. Quantified in the form of frequency rates, these can also be read as sociologically symptomatic of conditions in the area and its people. Table 7-1 presents Midtown's rates of known juvenile delinquency, tuberculosis morbidity, and four selected types of mortality among its residents. As baselines for comparison, rates are also given for the matching (white, non-Puerto Rican) resident populations of Manhattan and four outer boroughs of the City.[13]

First, we note that juvenile delinquency in Midtown, and in its parent borough as well, is approximately half again higher than in the rest of the City's white health areas. Even more striking is that the prevalence of known, active tubercular cases in Midtown, as among Manhattan whites, is twice larger than that in the outer boroughs. In rates of infant mortality, the differences among the three populations, although not so marked, are in the same direction as observed above.[14]

Turning to the three predominantly adult forms of mortality, we again see relatively sharp differences, especially in deaths due to alcoholism and nonvehicular accidents.[15] If in suicide rates the differences are not so pronounced, it will be remembered that the motivational line of demarcation between deaths appearing to be accidental and those certifiable as suicide is often difficult to draw. In cases where the evidence is equivocal, the benefit of the doubt upon certification by the family physician usually falls toward the former alternative. Rather more clearly, alcoholic fatalities are generally motivated by self-destructive tendencies. On these grounds, if we combine the three forms of adult mortality in section D of Table 7-1, the aggregate rate for Midtown is 80, for Manhattan 70, and for the outer boroughs 40.

The Midtown frequencies appearing in Table 7-1 can be followed

Table 7-1. Rates of Six Pathologies in Three White, Non-Puerto Rican Populations of New York City

Pathology	Midtown	Manhattan	Outer boroughs
A. Juvenile delinquents* in fiscal year March 1951–1952 (annual rates per 100,000 children age 5–20)	2,460	2,294	1,569
B. Active tuberculosis cases† on Dec. 31, 1951 (prevalence rates per 100,000 total population)	284	283	138
C. Infant mortality‡ in calendar year 1951 (annual rates per 1,000 live births)	27	25	20
D. Three other mortalities in calendar year 1951 (annual rates per 100,000 total population):			
Alcoholism	17	10	6
Suicide	15	15	9
Accidents—nonvehicular	48	45	25

* From Central Registration files of the New York City Youth Board, generously made available by its Research Director, Mrs. Maud Craig, to Dr. Alfred Parsell and his staff of City College of New York sociology students.

† From A. M. Lowell, *Socio-economic Conditions and TB Prevalence in New York City, 1949–51*, 1956.

‡ Sources for the four forms of mortality are:

For Midtown, tabulations especially made for this Study by Carl Erhardt and his staff in the Bureau of Records and Statistics, New York City Department of Health, to whom we acknowledge our gratitude.

For the boroughs, *Vital Statistics by Health Areas and Health Center Districts, 1951*, Bureau of Records and Statistics, New York City Department of Health.

further. As we have seen, this residential section is at a far extreme from homogeneity, and the six types of pathology reported above are not distributed at random in its population.

Rates for these pathologies were available to us only by health-area units that the New York Health Department uses administratively to divide the City. As a next step, let us cull out the Midtown health areas with the lowest and the highest rate for each type of pathology in turn.

Following the specifications indicated in Table 7-1, the range in these health area rates are:

Pathology	Lowest rate	Highest rate
Juvenile delinquency	360	5,010
Tuberculosis: morbidity	106	321
Infant mortality	14	45
Alcoholism: mortality	4	37
Suicide	8	25
Accidents: nonvehicular mortality	26	79

Thus, the frequency differences among Midtown's health-area units are substantial indeed. But such units are themselves highly heterogeneous in population composition. For three of these pathologies, however, we were able to secure the home addresses of the victims. When delinquency, tuberculosis morbidity, and infant fatality cases are spotted by residence on separate block maps of Midtown, an identical pattern emerges, namely, overwhelming concentration in the belt of blocks covered by five- and six-story walk-up tenements that were slum housing when they were newly reared by speculative builders around the turn of the century.

It is not necessary to make the simplistic assumption that such housing *breeds* the kind of pathologies concerning us in these immediate pages. If slums create an environment that in some part aggravates, magnifies, or triggers the complex conditions which issue in the above pathologies, there is sufficient warrant for including them in the overall picture of pathogenesis.

These objective criteria aside, under the democratic conscience the inequities of maintaining such housing have to be ultimately redressed. In point of fact, this has been implicit in the City government's actions between 1936 and 1956. With municipal, state, and Federal funds aggregating 2 billion dollars, the City in this period carried out a record program, accomplishing slum clearance and public housing construction of some 100,000 dwelling units. Manhattan alone secured about one-third of all these low-rent dwellings. Nor does this take into account the Island's substantial low-rent housing projects built by private institutions with one of several types of cost-reducing assistance from the municipality.

In 1938, the Mayor's Committee on City Planning surveyed the Midtown area, declared that its principal problem was housing, and recommended its core tenement belt to "demolition and rehabilitation." By 1950, when Midtown held 9% of Manhattan's entire resident population, the public funds poured into housing had not found their way to raze one Midtown tenement or to build one residential structure in the area. By 1955, the Community Council of Greater New York, in a report on Midtown, commented cryptically: "No public housing projects are located in this neighborhood and, so far as is known, none is planned."

These observations are offered here for their specific relevance to a matter mentioned earlier in this chapter. We refer to the necessity in a segmented population for central, integrating institutions of the voluntary, citizens' council type that addresses itself to overarching needs and problems in its own communal edifice. One of its minimal functions, in a residential section like Midtown, is to communicate its local requirements to the larger, governmental type of central institution. As a matter of fact, the highest elected authority in the municipal govern-

ment has explicitly voiced this principle: "From the beginning, this administration has not only shown willingness to listen to suggestions of community groups concerning matters of government policy and practice, but has actively solicited the aid of these groups." [16]

Midtown has not been without a voluntary central organization of its own. Indeed, for some years it had a housing council, but this expired without trace before the present Study began. A civic council, representing substantially the same territory as is covered in this Study, was formed in the years after World War I. From objectives such as furthering the installation of traffic lights, it shifted during the Depression years to gathering funds for relief and again, during the 1940's, to coordinating citizens' groups and voluntary agencies in the social service field. In 1952 it was reorganized as a constituent of the city-wide Welfare and Health Council.

It was not our purpose to evaluate this central institution. However, perusal of minutes of the predecessor body, attendance at several meetings by the present investigators, and reports from knowledgeable local informants were made possible. All these sources add to the impression that the Midtown Welfare and Health Council on the one hand was relatively strong in professional participants from local social agencies, including nationally known figures in the social work field who are versed in the skills of community organization. On the other hand, there is the decided impression that the Council was weak in representation and participation of segmental groups and of citizens-at-large. This contrast seemed to parallel a difference in perceptions of Midtown's housing problems and their consequences.[17] Apparently, the Council was thereby left voiceless and powerless to secure for Midtown's tenement belt the public rehabilitation program long recommended by municipal planning authorities themselves.

For a diagnosis of the difficulty in Midtown's sole voluntary central institution, a parallel may be found in the *New York Times'* notable series of articles on factors behind the City's chronic juvenile delinquency problem:[18]

> Lack of vigorous civic effort can unquestionably be proved. But it would seem that the roots of the problem lie deeper—in the feeble participation by ordinary citizens in political life, in an increasing concentration by the community's most able leaders upon the more distant horizons of business, banking and national politics. . . . The plain truth seems to be that . . . the city and most of its inhabitants have been content to drift and make do. 'Let George do it' has been a convenient motto for too many. . . . Too many persons have stood by idly, content and confident that the city's multiform social agencies are handling the problem. . . . Today the fearsome harvest is being reaped.

Lack of a broad base of citizen interest and support seems to account for the impotence of Midtown's own central institution in relation to

its slum housing and derivative problems. However, this condition is not inherent in the metropolis. Through the City's alert press, it has been possible to keep an observant eye on other of Manhattan's residential sections as they contend with their own local problems.

One extremely heterogeneous Manhattan area has a vigorous neighborhood association that has received attention in national magazines. Its "purpose is nothing less ambitious than to unite all the social, civic and religious groups in the area into one body that works for common goals." According to a newspaper account, this federation of four neighborhood councils is "a citizens' self-help association organized to improve [its area]. It conducts a youth division to combat juvenile delinquency, sponsors an art show and open-air concerts, and operates a job-finding office for hard-to-place youth; as well as other activities."

Another Manhattan residential section formed a community council, consisting of 79 religious, civic, business, labor, veterans', and parent-teachers organizations. Its goal was to combat the area's "deteriorated housing and other problems." Within months of its formal organization City officials were engaged with the council in working out a large scale redevelopment plan that included a low-rent public housing project. The plan is now well advanced toward implementation.

The central citizens' organization in a third Manhattan area successfully fought determined official efforts to cut up a local park for auto traffic purposes. Explaining this outcome, a resident wrote a local newspaper editor: "Most people never know the feeling of community in the hugeness of New York City. This lack of community feeling is a basic cause of many New York City problems. [This district] is a rare exception—a community whose inhabitants have a feeling of belonging."

A striking point in Midtown's absence from this small company of exceptional Manhattan areas is that its assets in resident financial wealth, leadership resources, and segmented institutional strength are probably not exceeded anywhere else in the borough or the City. The large default of Midtown's middle- and high-income groups in not assuming their share of the common responsibility seems to differentiate this area from the exceptional districts with records of problem-solving accomplishment.

All in all, the Midtown adult population is partially organized within its group segments, principally around religious and secular recreational institutions. It has struggled, so far unsuccessfully, to sustain voluntary, area-wide institutions that could act to correct certain glaring, long-standing environmental conditions with public funds directly at hand.[19] In the sociological view, this is a failure to meet the final criterion of a full-fledged, integrated, and need-responsive community. To be sure, for a residential section of a great metropolis, such fulfillment is beset with real difficulties, but elsewhere in the same city it has proved to be not in the realm of the impossible.

THE PSYCHOSOCIAL CLIMATE

Up to this point, we have been regarding Midtown from the sociological perspective of its extrafamily institutions as these constitute the organized, communal edifice of its human environment. However, there are more subtle aspects in the psychosocial climate of informal interpersonal relationships that are relevant to our descriptive purposes. For evidence on several of these aspects we shall turn principally to the writers on Manhattan, many of them Midtown residents.

One of the most persistent themes in the literature on Manhattan, sounded in many variations, refers to its hustle, frantic speed, breakneck pace, etc. One newspaperman wryly quoted "a sociologist who works for a living running a night club" to the effect that "New Yorkers are perpetually drunk—not with whiskey, but with motion." Doubtless this quality in Manhattan led Christopher Morley to characterize it as "the nation's thyroid gland," and expatriate Frank Sullivan to taunt its residents: "Where are they all hurrying to so frantically? . . . What's biting them? Are they afraid they'll be late for that coronary they think they must have at fifty? . . ." [20]

One observation offered about this phenomenon is: "You'll find, if you're in New York for more than a few days, that the mill-race way of living gets to be a habit. You're a human ship in a fast-moving tide and by and by, without meaning to, you find you're accommodating your pace to the common tempo." [21]

Another interpretation emphasizes the competition, seen as tough, fierce, or fantastic, in a population "seething with determination to forge ahead," and in an environment where "one has to work harder, hustle more than anywhere else." Involved here is a way of life set to a tempo that many writers epitomize with the phrase "the rat race of the job."

Of course, the metropolis is preeminently the place offering opportunities for economic and social advancement. In drawing to itself a migrant population largely motivated to actualize these opportunities, a hypercompetitive society is created of people "on the way," who at the very least, we are told, "must hurry even to remain where they are."

Manhattan's tempo appears to have its origin at least partially in the work and career areas of life. On the other hand, its quality of personal anonymity seems to derive from other social sectors of metropolitan existence. This facet can perhaps be best identified from the perspective of the small community. Describing the New England village in which he lives, Granville Hicks[22] comments:

> No one can write about such a place as Roxborough without emphasizing patterns of thought and action that distinguish the small town from urban life. . . . In the small town you know everybody or nearly everybody, and, what

is more, you know a considerable number of persons in a considerable number of ways. [Here] no local event . . . birth, illness, change of job, real estate transaction . . . is likely to go unremarked. [You discover] the simple fact of interdependence: you need your neighbor and he needs you. Whatever its origins, neighborliness has gone deep into the grain.

The contrasting situation of "a city of strangers" is drawn by John Steinbeck through the eyes of the City's new recruit from the hinterland:[23]

A young man in a small town, a frog in a small puddle, if he kicks his feet is able to make waves, get mud in his neighbor's eyes—make some impression. He is known. His family is known. People watch him with some interest, whether kindly or maliciously. He comes to New York and no matter what he does no one is impressed. He challenges the city to fight and it licks him without being aware of him.

Offering another vantage point is the novel[24] in which the chief character, Anson Page, muses about an acquaintance as follows:

The [suburban] world of Eugene Hollister was not one in which he [Page] would choose to live, but at least it provided Eugene with the illusion of having a place. That was more than he could say for himself. There were times when he felt that he did not belong anywhere, and this was one of the times. He had not felt that he belonged anywhere since he left Pompey's Head. Nor could it be said that he had failed with his group. He had no group. Sometimes he wondered if anyone in New York had. There were circles and cliques in New York, people drawn together by the same profession or a loose collection of momentarily shared interests . . . but these were temporary associations at best. The interests were always changing, and the faces with them, and there was always the feeling that everybody you met in New York was just passing through, or else on an extended visit, so that there were times when you had the impression that it was not so much a city as a big, endless game of musical chairs.

Phillip Greene once remarked to him that although New York was a collection of neighborhoods it was a place where nobody had any neighbors. "Some people say that this is one of the fine things about the city, but I don't think so," Greene went on. "A man wants neighbors. He may want to put a fence between himself and them, but he wants them just the same. The trouble with New York is that it imposes a set of unnatural conditions. Nobody knows anybody, even when they live next door to each other. You can make your home here for fifty years and still feel a stranger. I know I do."

Though Anson was barely acquainted with Phillip Greene at the time, he was surprised to hear him voice a set of feelings that were so close to his own. Greene was one of the people whom he had imagined as being completely at home in New York.[25]

John McNulty generalizes the point in the following words:[26]

There are afflictions called "Parkinson's Disease" and "Bright's Disease," and so on, but loneliness is "Everybody's Disease." It is especially rife, and there is no serum handy, in cities like New York.

Anonymity is a form of isolation; one's defense against the rejection implied in the isolating, impersonal behavior of others is to insulate himself from them. This mechanism was observed by a local newspaper columnist in the City's restaurants and lunch counters, where he identified among diners the phenomenon of "luncheons anonymous." "The basic essential of the whole concept is the elimination of all communication beyond the absolute minimum needed to obtain food; where this can be done without affirming choices by voice or asking simple questions of an attendant, so much the better."

When a visiting Italian monk suggested that New Yorkers "are hermits at heart," the same newspaperman further developed the reechoing theme that New York can be the loneliest place in the world: "When our solitude is clothed in that mantle of impersonality we tend to be brusque when we might better be kind, or thoughtless when we should be considerate, or even downright rude when we know we should be polite. The solitude of hermitage, improperly used, tends to harden the soul and the face as well—if one may judge by some of the unhappy expressions worn by the people on our streets."

Here we have testimony that the casual interpersonal relationships of the metropolis carry not merely the neutral or cold aspect of indifference; to the normally sensitive individual, they are frequently tinged with bruising harshness. Spreading by disaffection into more intimate kinds of relationships, this quality can produce a partial breakdown in the person-to-person private lines of communication. Such a social process can turn out to be psychologically impoverishing, pushing the individual toward a state that the present writer has elsewhere identified as *anomia*.[27]

On this theme, it has been observed by one of New York's major social agencies: "In a big city like New York, sickness, loneliness, trouble, a need for help, can be inches away from you . . . on the other side of the wall . . . and you may never know." [28]

The blocked need to be an object of sympathetic communication may be discerned in local commercial uses of the telephone, not as a mechanical medium but rather as a robot communicator. One arrangement is actually designated "Sympathy Service," and is specifically directed to women who, upon calling a given telephone number, can pour out their troubles to a male who, according to a newspaper account, "makes comforting noises at the other end of the line." [29] A parallel but independent telephone service for men plays a recording of a sultry female reciting a flirtatious monologue. As another case in point, several Manhattan churches sponsor a "Dial-a-Prayer" telephone service "for troubled people" who can hear a recording of a prayer uttered by an anonymous clergyman.

Without challenging the facts about this element of anonymity in

the social climate of the metropolis, many writers have evaluated it positively. For example, John Lardner notes the high value Manhattanites place on privacy and adds: "Privacy is the rarest condition in modern life, and New Yorkers, for all the physical crowding that exists in their city, have achieved it to a degree beyond the powers of people in other places." [30]

Alec Waugh[31] elaborates the point: "It is the charm of all great cities that you are not supervised, that your every movement is not watched and commented upon . . . that you can lead your own life undisturbed." [32]

Certainly it cannot be overlooked that the freedom to be yourself in the private sectors of one's life, and the opportunities to realize one's capacities, talents, and interests, arise from the tolerant anonymity and the vast economic and cultural diversity of the city, justifying its characterization as the natural environment of free men. Going further, philosopher Irwin Edman has noted that in Manhattan "the spirit has many mansions and there are many incitements to the spirit. For all its distractions, its rush, its brashness, there is hardly a place in the world where there are so many nourishments for the life of the imagination and the mind." [33]

Showing both sides of the coin on this element in Manhattan's social climate is the observation: "On any person who desires such queer prizes, New York will bestow the gift of loneliness and the gift of privacy. It is this largess that accounts for the presence within the city's walls of a considerable section of the population. . . . The capacity to make such dubious gifts is a mysterious quality of New York. It can destroy an individual, or it can fulfill him, depending a good deal on luck." [34]

Under ordinary circumstances of life, in our view, people of more or less sound personality thrive on balance in the freedom and privacy of metropolitan anonymity, as no doubt do many deviants and disturbed personalities who find in the metropolis "sanctuary from the prying eyes and clacking tongues of small-town neighbors." [35] Most people who remain in Manhattan by choice have probably come to terms, as did John Steinbeck, with its characteristic of ignoring and looking through the individual's claim to personal identity, worth and attention. If this should evoke a sense of isolation and loneliness, they can accept it as the price to be paid for more important values found only in the metropolitan environment. It is in this sense that Heywood Broun could comment that "Manhattan is the place of sacrifice. It is only for those who can subsist on locusts and honey." [36]

However, under personal circumstances that are extraordinary and potentially damaging (e.g., the crises of prolonged illness, death, disability in one's family, or unemployment), the response of town and

metropolis would likely be somewhat different. That is, the town, with its highly developed sense of person-to-person interdependence and social mechanisms of mutual aid, as delineated by Granville Hicks, would probably rise spontaneously to provide the afflicted with sociogenetically "primitive" group supports that tend to be psychologically stabilizing because they operate to share and absorb the shock. In the indifference and isolation of the metropolis, on the other hand, the same crisis often rallies relatively few intimates around the distressed.[37] To discern the full import of this difference, one need only note in town and metropolis the very different mobilization of others around families that have suffered a death. This has been sharply revealed to the present writer by comparative observation of funerals in the two kinds of communities. Thus, sociologists have emphasized that "one effect of the urban environment is to intensify the effects of crisis." [38]

Our literary sources are not wanting in observations about the resulting psychological condition of metropolitan man. Frank Lloyd Wright sees the metropolis as "forcing anxiety upon all life." From the perspective of long residence, E. B. White concludes: "New York has changed in tempo and temper during the years I have known it. There is greater tension, increased irritability. You encounter it in many places, in many faces. The normal frustrations of modern life are here multiplied and amplified." [39] Newspaperman Brooks Atkinson hears in New York "the nervous beat of a taut community." In one of his recent plays Thornton Wilder, creator of Grover's Corners, describes New York as "a tired out, nervous collection of ants." The inimitable *New Yorker* magazine has run this item of "appraisal"! "A pal of ours just had his annual medical checkup, and informed us that the doctor who went over him was disturbed about his blood pressure, his pulse rate, his basal metabolism, and a lot of other things. 'I thought you ought to know,' said our friend, 'that after all his muttering about the poor shape I was in, he told me I was 'New York normal.'"

And, of course, there is a whole genre of essays with content suggested by the title of one: "The Crack-up City." [40] However, caution is here urged against generalizing from these sensitive observers and arriving at premature conclusions about the psychologically noxious characteristics of Midtown's physical and social environment, not, at least, until comparable research data become available on populations in other kinds of American communities.

Granville Hicks, as journalist, does not attempt to measure the prevalence of mental disturbance in his New England place that houses a population numbering less than a thousand individuals. Yet his perceptions of this village community offer a sobering hint that we suspend judgment on Midtown until we have a larger base for comparison. He writes:[41] "Roxborough . . . has its share of neurotics. . . . I cannot be

absolutely sure that in any particular instance the condition is related, one way or another, to small-town life. The chief point is that even a small town has its instances of nervous disorder. . . . We have our neurotics, our drunkards, our 'bums.' And what is more, we know we have them."

Closing this attempt to portray the Study area in certain salient characteristics, the author concludes from a personal history of a lifetime divided among three of America's largest cities, from a professional background of investigations in several small American communities, and from an eight-year period of research immersion in Midtown, that he stands neither with the advocates who find in Manhattan the penultimate stage of the heavenly city nor with those who regard it as a preview of purgatory.

Rather, from outside that frame of values, he views it simply as the culminating summit in the long, upgrade development of American urban civilization. Whether the rarified, turbulent atmosphere and slippery footing at this peak are in themselves psychologically eugenic or pathogenic for those willful, hardy people who have climbed to it —and remained—is a question that this report can touch only peripherally. We must look to successor studies, conducted at other points on the grade, for the larger clarifications of the comparative perspective.

FOOTNOTES

[1] The term has so few synonyms that its overworked use in the following pages is unavoidable.

[2] Because the variety of institutions is so large, at certain points we shall have to arrange them in a number of large categories.

[3] This compares with 13 in 1938, suggesting a historical trend toward increasing concentration of hospitals in the area.

[4] Cf. *Mental Health Resources in New York City*, New York City Mental Health Board, 1957, pp. 69–71.

[5] Some of the churches are identifiable by the character of their names as being associated with a particular ethnic, i.e., nationality, group, and others, while lacking such designation, are in membership predominantly drawn from one of these groups.

[6] It is possible, in turn, to distinguish between the serve-others association of laymen and the serve-others agency with a professional staff that the former creates and is committed to support.

[7] From notices in the society pages of the city newspapers, it is clear that the members of these organizations are largely, but by no means exclusively, drawn from the Midtown area.

[8] As is usually the case even for lower-class Old American secular organizations, the serve-others function is negligible, being channeled by financial necessity into self-service and mutual aid shared among the members.

[9] Of course, the numbers of institutions of each type are no indicators of their respective enrollments, which are unknown to us. In New York City at large we know that about 30% of school-age children attend parochial or private schools. We have grounds to assume that in Midtown this figure may fall in the 40 to 45% range.

[10] Roughly one-third of this sum came from the City's budget, the balance from Federal and state governments.

[11] Published for the Community Council of Greater New York, Inc., by Columbia University Press.

[12] R. W. Houston, commissioner, New York State Department of Social Welfare, "Why All This Welfare?" Address to the annual meeting of the New York City Federation of Protestant Welfare Agencies, Feb. 25, 1958.

[13] For the six pathologies in the series, case frequencies are available in common only for the City's "health areas," each a Health Department administrative unit comprising several United States census tracts and a population usually approximating 25,000. The frequencies reported derive from official records and have obvious limitations which we need not define here.

To match the two comparison populations to Midtown, we have included only those health areas in Manhattan and the outer boroughs with populations in 1950 that were 90 to 100% white, non-Puerto Rican in composition.

Rates have been calculated for each of the outer boroughs separately, i.e., Bronx, Brooklyn, Queens, and Staten Island. However, there were no significant differences among these four boroughs; as a result, we can more efficiently present them as a unit.

[14] Of course, infant mortality rates vary inversely with amount of prenatal medical care received. The latter in turn varies to a certain extent with the local availability of medical services. Accordingly, it is plausible to assume that if the outer boroughs' population had the same advantages in this respect as have Midtown's and Manhattan's, their infant mortality rate would have been even lower than that observed.

[15] There are no differences among the three populations in rates of automobile fatalities.

[16] Hon. Robert E. Wagner, "Address of the Mayor of New York City to the City Council upon Presenting his Annual Report for 1955."

[17] At one well-advertised Council meeting attended by the writer, a local realtor gave an informal address advancing the theme that Midtown's housing is "in excellent shape." He was followed by a municipal housing expert who took a dissenting view and chided his 40 listeners that Midtown had no specific organization concerned with its housing problem or its shortage of playgrounds. "You can't sit by and let George do it," he pointedly declared. "You have to work with city-wide bodies and local citizen groups."

[18] Harrison E. Salisbury, "The Shook-up Generation," Mar. 30, 1958.

[19] The report of the New York City Housing Authority for 1959 revealed for the first time that in the planning stage for Midtown is a housing project to be supported by Federal funds. Nothing more is known now about this development except that it will rise near one corner of the Midtown area, on a previously nonresidential site, and when completed will comprise approximately six hundred apartments. Also in current planning for the City as a whole, parenthetically, are 37 other publicly supported housing projects, to provide a total of 28,000 new apartments.

[20] *The New York Times Magazine,* Apr. 29, 1956.

[21] Meyer Berger, *The New York Times Magazine,* Apr. 29, 1956.

[22] Granville Hicks, *Small Town,* 1946, p. 13.

[23] John Steinbeck, "The Making of a New Yorker," *The New York Times Magazine,* Feb. 1, 1953.

[24] *The View from Pompey's Head,* pp. 117–118. Copyright 1954 by Hamilton Basso. Reprinted by permission of Doubleday and Company, Inc.

[25] We can test the impression of Phillip Greene (a character from Basso, *op. cit.*) that New Yorkers predominantly share the almost universal want for friendly neighbors. To our Midtown sample respondents we put this question: "People say that in smaller cities neighbors are helpful and interested in each other. Is this something you would like or dislike?" Only one-sixth of these Midtowners replied "dislike," another 9% gave a qualified "like" response, and three-fourths indicated unequivocal approval.

[26] John McNulty, "Search for the Perfect Bar," *The New York Times Magazine,* Oct. 10, 1955.

[27] L. Srole, "Social Integration and Certain Corollaries," *Am. Sociological Rev.,* vol. 21, no. 6, pp. 709–716, December, 1956.

[28] *The Greater New York Fund Bulletin,* 1957.

[29] The enterprising young organizer of this service has detected the gulf between New Yorkers and their intimates in what they *do not* reveal to each other. He has said: "It's a moving, distressing experience. The only trouble is, I've begun to wonder what my girlfriend really thinks of me."

[30] John Lardner, "The Case for Living Here," *The New York Times Magazine,* Apr. 29, 1956.

[31] Alec Waugh, *The New York Times Magazine,* Apr. 29, 1956.

[32] It is important to emphasize that although this consequence of anonymity applies to places like Manhattan, there are sections of the metropolis with far lesser population densities, where personal visibility differs little from that characteristic of the small community. For example, dramatist Arthur Miller writes of his boyhood neighborhood in Brooklyn: "It was a village. . . . I don't recall a time when the cops had to be called. Everyone was so well and thoroughly known that the frown of his neighbors was enough to keep things in line." "A Boy Grew in Brooklyn," *Holiday,* March, 1955.

[33] Irwin Edman, *The New York Times Magazine,* Feb. 1, 1953.

[34] E. B. White, *Here Is New York,* 1949, pp. 9–10.

[35] Meyer Berger, in A. Klein (ed.), *The Empire City,* 1955, p. xx.

[36] Heywood Broun, in A. Klein (ed.), *The Empire City,* 1955, p. 450.

[37] As substitutes for such "intimates" the metropolis may provide, under certain limited, qualifying conditions and upon formal application, the professional and bureaucratized services of a social agency. Such services are not to be minimized if they are sought; if resources, eligibility policies, and case load of the agency allow response in time; and if help extended is adequate to the need. Such multiple contingencies probably explain facts earlier noted that the unserved needs may be large indeed.

[38] Robert E. Park, *The City,* 1925, pp. 1–46.

[39] White, *op. cit.,* p. 48.

[40] Helen Lawrenson, "New York: Crack-up City," *Esquire,* July, 1953.

[41] Hicks, *op. cit.,* pp. 149–152.

PART III

Midtown Mental Health Composition and Psychiatric Care

CHAPTER 8 *Midtown and Several Other Populations*

Leo Srole

On a broad canvas we have now sketched Midtown as a local habitat, as a population, and as a community. In the long national perspective, it appears neither typical of the American scene nor unique to it. Instead, Midtown is seen to be representative in most demographic respects of the inclusive (non-Puerto Rican) white population of Manhattan, and apparently of populations in similar high-density core residential sections found in other major American metropolitan centers. Beyond these special characteristics, it can also be surmised that our study area and the people who settle it express certain basic tendencies in American life, carried, however, to an extreme point of development. To adapt an aphorism from another context, Midtown in this respect is like the rest of America—only in a decisively more concentrated form.

Against this descriptive backdrop, our primary purpose here is to draw upon Study findings that reveal something about mental health and psychiatric care behind the façade of Midtown as a social entity, and second, so far as possible to compare these revelations with results yielded by studies of other American populations.

TREATMENT CENSUS FINDINGS

On the principle that the known is a convenient point of departure in the search for an unknown, we might start with Midtown's residents who are known to psychotherapists as patients. It was one task of our Treatment Census operation to enumerate all bona fide Midtowners *of all ages* who on our census day, May 1, 1953, were on the "active" rosters of the following in-patient facilities available to the Manhattan population:[1]

8 state mental hospitals
2 Veterans Administration psychiatric hospitals
2 Veterans Administration general hospitals with psychiatric divisions
1 municipal psychiatric hospital (short-term care only)

7 voluntary (nonprofit) general hospitals with psychiatric divisions in Manhattan

23 licensed, private (proprietary) psychiatric hospitals and sanitoriums in New York State

11 private (proprietary) psychiatric hospitals in adjoining states

In Table 8-1, the 864 in-patients distributed among the several types

Table 8-1. *Treatment Census* (Age Inclusive) Prevalence Rates of Midtown In-patients* (per 100,000 Population) by Type of Hospital

Publicly supported hospitals:	
State	435
Municipal	12
Federal (VA)	9
Total public hospitals	456
Privately supported hospitals	46
Total all hospitals	502

* Hospitalized less than five continuous years. Includes undischarged patients in family or convalescent care.

of hospitals are expressed in one-day prevalence rates per 100,000 of Midtown's total resident population. In brief, for every 1,000 people having a Midtown residence as their home base, five, according to our criterion, are confined in psychiatric hospitals.

By separate inspection of the Treatment Census patients in private hospitals, we find that 20% have been hospitalized between 12 and 60 months, whereas the corresponding figure for the Midtown patients in public hospitals is 64%. Calculated differently, the former have been in the institution for 10 months on the average, and the latter about 2 years.[2]

If length of hospitalization in these two patient groups is strikingly different, in another respect the groups are identical: about one-third of both are readmissions, i.e., are now hospitalized at least for the second time.[3] It would appear, therefore, that if private hospitals more quickly return their patients home, their results in preventing relapse and rehospitalization are not perceptibly better.

Because no previous prevalence study of in-patients has employed our limiting criterion (i.e., under five years of hospitalization), it is not possible here to place the above data in the comparative perspective of other hospital populations.

However, no such limitation was indicated for or applied to Midtowners in ambulant treatment (on our census day) while continuing to live at home, including 290 reported on the rosters of some 50 psychiatric clinics.[4]

Solicited through personal letters from Rennie were the patient reports of 798 psychiatrists and 316 clinical psychologists known to have private offices in Manhattan.[5] About 10% of these therapists explicitly refused their cooperation or did not reply to the several Rennie letters. The cooperating therapists, on the other hand, reported 959 Midtown residents as patients on May 1, 1953.[6] The error of understatement due to the noncooperating therapists could be objectively estimated and corrected accordingly.[7] With this correction introduced, Table 8-2 presents the

Table 8-2. *Treatment Census* (Age Inclusive), Prevalence Rates of Midtown Out-patients* (per 100,000 Population) by Type of Service with Comparable New Haven Psychiatric Census Rates

	Midtown (May 1, 1953)	New Haven (Dec. 1, 1950)
Clinic	168*	67‡
Office	620†	157‡
Total	788	224

* Estimated by Midtown Study social workers to be about 95% complete.
† Corrected by estimation for noncooperating therapists but not for underreporting by cooperating therapists.
‡ Estimated by New Haven investigators to be about 98% complete.

clinic and office patient prevalence rates per 100,000 Midtown population, together with comparable rates calculated from percentaged data reported by the New Haven study.[8]

Let us focus first on the Midtown side of the picture. Combining hospital and ambulant patients, we arrive at a total reported patient rate,[9] on our census day, of 1,290 per 100,000 of the entire Midtown population. Since the average Midtown residential block houses about 1,000 people, this combined rate can be stated in a more concrete form: In each Midtown block on any given day there are an average of 13 individuals reported in the care of a psychiatric service, with 8 of the 13 known to be in an out-patient facility and 5 in a hospital.

Nothing is known directly concerning the nature of the treatment being received by these out-patients. However, indirect suggestive evidence has been reported by a nationwide study of 380 psychiatric clinics and their patients. About these clinics we are told that "of each ten patients terminated during the year [ending June 30, 1955], three received diagnosis and treatment, four received diagnosis only," the remainder apparently getting even briefer types of service. Only 20% of all terminated patients had been seen in ten or more clinic sessions.[10] Whether these findings also apply in exact detail to Midtown clinic

patients is uncertain. But even had *all* of these listed patients begun actual treatment, the benefits resulting may be suggested by a study made several years earlier, involving 288 patients of New York City clinics.[11] In summary statement, "only about one-fourth of the patients *accepted for treatment* [italics added] were rated as having received significant help."

Together with evidence that four in five of all New York state hospital patients (in 1955) were receiving custodial care only (see footnote 2), these indications from the psychiatric clinics warn against any generalizations about the therapeutic significance of patient status in a psychiatric facility.

Table 8-2 also includes the out-patient rates we have computed from the parallel prevalence study earlier conducted in New Haven, Connecticut. Comparison of the two sets of rates in the table immediately evokes this question: How are we to account for the intercommunity differences there revealed?

Before addressing ourselves to this question, we might briefly consider the diagnostic range among the ambulant patients. Previous hospital investigations in many instances viewed in-patient rates as reflecting the frequency of psychotic conditions in the general population, with the out-patient rates inferred as representing the frequency of less disabling, nonpsychotic disorders. Analysis of the diagnostic composition of the reported New Haven and Midtown out-patients reveals that the proportion of psychotics in each[12] stood at 24 and 15%, respectively.[13] Focusing on specific psychotic conditions among all reported Midtown patients, we learn that in ambulant care were 40% of the manic-depressive cases, 36% of the nonparanoid schizophrenics, 25% of the nonsenile chronic organic conditions, 14% of the paranoid schizophrenics, and 22% of all other psychotics exclusive of the seniles.

In both communities, it is clear, substantial fractions of the diagnosed psychotic group are ambulant patients. Accommodations for psychotics in local out-patient facilities have undoubtedly diverted not a few of them from their respective state hospital systems—both known to be overcrowded by margins of about 25 to 30% beyond their certified bed capacities. In this light, in-patients certainly do not qualify as a reliable index of the frequency of "treated" psychosis in an urban population. Actually, it is highly probable that inter-community differences of in-patient rates partially reflect variations in bed capacities and admission policies[14] in the mental hospital systems serving different states and communities, as well as differential availability of alternative services.

If we now focus only on the reported nonpsychotic conditions (principally neuroses and personality disorders) in the care of out-patient facilities, we find a prevalence rate per 100,000 population of 616 in Midtown and 164 in New Haven,[15] a difference of about 3.7:1. Is it pos-

sible to assume that this disparity reflects a like difference between the two populations in the *over-all* frequency of the nonpsychotic disorders? Are these conditions really three to four times more prevalent in Midtown than in New Haven? Before this possibility can be seriously entertained, other alternatives should certainly be considered. One plausible alternative open to testing is that the observed difference is related to variations in the treatment capacities of the psychiatric out-patient facilities accessible to each population.

Taking into account only the *number* of locally based out-patient clinics, we find that per 100,000 population Manhattan at the time of our Treatment Census had 2.2 times as many clinics as did New Haven when it was being studied. Hardly by coincidence Midtown's clinic patient rate stands to New Haven's in a ratio of 2.5:1 (Table 8-2). Next, marshaling psychiatrists and clinical psychologists[16] locally in office practice (full-time or part) during the two investigations, we calculate their number per 100,000 population as 57 in Manhattan and 13 in New Haven, a difference in the magnitude of 4.4:1.[17] Again by no coincidence, the office patient rates of Midtown and New Haven stand to each other as 4.0:1. It is accordingly difficult to reject the simple inference that clinic and office patient rates are to a considerable degree determined by size of treatment capacities supplied by local out-patient services.

A two-part principle of supply and demand can here be stated to fit the situation just observed. First, the *supply* of treatment services made available in a community is undoubtedly influenced in the long run by the pressures of local need and *demand* for such services. However, at any given time if such supply in two communities is at different removes *below* current demand, then their respective out-patient rates will inevitably reflect their differences in supply level, rather than in demand level as influenced by the mounting local backlog of untreated pathology.

Under the leavening influence, direct and indirect, of Yale University and its medical school, New Haven stands well above the national average and above sister cities of its state in supply of psychiatric out-patient services relative to population size. In turn, Manhattan stands well above New Haven in this particular respect, at a point perhaps unmatched anywhere else in the nation.

Yet, in neither place is there evidence that this supply is even approaching saturation relative to manifest local demand. In both communities the steady growth in number of office therapists during the years 1947 to 1957 [18] bears witness to a supply situation that was far from sighting demand at the time of the respective studies.

Even more hard pressed are the psychiatric clinics. Of New Haven we are told that, "the demand for (clinic) treatment far exceeds its availability." [19] In Midtown, the phrase *"very lucky,"* as frequently applied

to a successful applicant for admission to clinic treatment, is itself a symptom of deep undersupply. By way of one concrete instance, a new private, low-cost Manhattan clinic for adults opened in 1955. During its first twenty-one months of operation it received almost 11,000 applications for help. It could not extend psychiatric service of any kind to more than 500 of these. Thus, even in this new institution lacking the barrier of an initial waiting list, the chances of acceptance over this span of time were no better than 1 in 22.

As we shall see in the next chapter, clinic services for children in New York are *relatively* more plentiful than for adults. Yet in 1956 the director of the City's Bureau of Child Welfare announced a large backlog of preadolescent children "needing treatment for emotional disturbances [who] may have to wait one or two years before they can enter one of the seven available agencies here." He added that the chances for disturbed adolescents were "even less promising." Finally, one citizens' organization, for evidence of "overwhelming demand for service," pointed to "the long waiting lists at treatment agencies, with frequent closure of intake [that] often adds to the aggravation of the patient's original problem." [20]

That facilities for ambulant psychotherapy (as for hospitalization also) in both Manhattan and New Haven are clogged bottlenecks relative to immediate needs cannot possibly be questioned. How far they fall below the respective local demand levels was unknown while the studies were being conducted. Thus, the line of reasoning just developed in no way precludes the possibility that a real difference *does* exist between Midtown and New Haven in the over-all prevalence of nonpsychotic disorders. Precluded, however, is this: If such an intercommunity difference should happen to exist, neither the direction nor the magnitude of the difference can be inferred from the nonpsychotic out-patient rates. Precluded earlier was this: from the hospitalized psychotic rate cannot be inferred the total psychotic *patient* rate, and even less does it lend itself to inferences about the *over-all* frequency of psychotic conditions in a community population.

In short, the very bottleneck constriction of psychiatric services, relative to the mounting backlog of unserved local need for treatment, has this inevitable effect: It renders *number* of patients almost worthless as an indicator measure of *over-all* mental morbidity in a population. The latter is the elementary but elusive unknown sought fruitlessly in numerous epidemiological studies of psychiatric patients.

THE HOME INTERVIEW SURVEY: PROCEDURES REVIEWED

The shortened, unstable shadow of the above unknown is cast on institutional records. To proceed toward its substance requires a far

bolder research strategy, one pointed directly at representative people in the community rather than at the records of patients registered in psychiatric care.

Before indicating the toll paid to follow this course, it will be recalled (Chapters 3 and 4) that its execution was entrusted to the Study's Home Survey operation.

At this point it may be useful to review our bearings by highlighting the differences between the Home Survey and Treatment Census operations of the Midtown Study. Since certain results of these twin field projects are reported in tandem fashion through all data chapters, clarity may be enhanced by reemphasizing the features that give each operation its distinct identity. These are set forth below:

	Treatment Census	Home Interview Survey
Date of coverage	May 1, 1953	November, 1953-July, 1954
Number of people covered	2,240*	1,660
Age range of these people	Entire age span	Age 20–59 adults only
Mode of selection	Selected psychiatric patients on rosters of treatment services	Probability sampling of Midtown resident population in indicated age range
Proportion of universe from which drawn	Approximates entire universe of Midtown psychiatric patients on Census Day	15 per 1,000 of *all* adult Midtown residents in the indicated age range.
Source of information	Records of therapeutic facilities only	Face-to-face two-hour interview and secondary sources

* Corrected for patients of noncooperating office therapists and excluding in-patients hospitalized more than five years.

Psychiatric patients as the focus of epidemiological study are unreliable indicators of the complete extent of mental morbidity in a general population. However, they do offer a specific, or at least an official, diagnosis for each patient, one that the investigator need only copy from the institutional file.

By contrast, the epidemiological study focused on a community population may be on the only direct path that can lead to a competent estimate of over-all prevalence therein of mental morbidity. However, this kind of investigation must first itself secure basic data on symptoms of morbidity from each sample respondent, and then by its own devices it must also synthesize the information about each individual in terms of a limited number of psychiatrically relevant categories. Because of the particular nature of the symptom data secured and the special character of the assessment situation, each deviating far from its optimal counterpart in the treatment setting, psychiatric classification of the

sample Midtown respondent could not be safely modeled on the diagnostic specificity ultimately entered on the record of the patient.

The sacrifice of such nosological refinement is the price often exacted from large-scale epidemiological investigations of this kind. Clausen defines the elementary dilemma faced by a researcher in such a field: "If he wishes reasonably well-diagnosed cases he must, by and large, work with patients who are hospitalized or under treatment, recognizing that they constitute only a part of the total group suffering from a given illness. If, on the other hand, he wishes to approximate a total count of disturbed persons in some limited group he must accept less reliable diagnosis." [21]

Planning his over-all prevalence study of mental illness among the aged population of Syracuse, Gruenberg confronted this dilemma and concluded: "For various reasons no attempt was thought to be feasible in this particular study to differentiate [nosologically specific] mental disorders from one another." [22]

Elsewhere, he has offered partial amplification:[23] "We would like to be very scientific and concentrate on etiologically defined disease entities. . . . Unfortunately, in psychiatry such entities have not yet been defined for the most part." [24]

Another consideration pointing community surveys in the same direction is indicated by Clausen:[25]

> Unfortunately, the standard diagnostic nomenclature is designed for classifying full-blown pathology. There is no evidence that high reliability of diagnosis can be achieved in the early stages of illness. Indeed, the frequency with which changes are made in provisional diagnosis given when the patient is admitted to a mental hospital suggests that a period of observation is often necessary to check on the course of the disturbance. Therefore, few clinicians feel any enthusiasm for assigning a diagnostic label to persons about whom their information is limited.

Chapter 3 documents the carefully selected sample of signs and symptoms covered in the Home Survey interview, many serving as validated indicators associated with depths of pathology characterizing psychiatric patients. Nevertheless, it was Rennie's position that symptomatic information of this kind offered the psychiatrist no firm perceptual footing to discern intrapsychic dynamics. The latter, of course, are the *sine qua non* of operable data for diagnosis within psychiatry's rapidly evolving nosological framework.

The unavailability of this framework for the Home Survey sample created a heavy problem for the Study's psychiatrists, namely, that of formulating a classification scheme that (1) would be appropriate to the Midtown respondent's interview data and (2) would be psychiatrically meaningful as well.

The ultimate solution to the problem can here be summarized for

nonpsychiatrists, as it was viewed by the Study's senior sociologist (a nonparticipating observer of the problem solving), on lines of one generic kind of scientific categorization. The classification system finally devised by Rennie, with the assistance of Kirkpatrick, has already been discussed in Chapter 4. Comparison is possible with certain investigations of somatic disease providing a roughly equivalent mode of classification. Instead of assigning a population's chronic somatic illness cases to one or another rubric among the large series of specific disease entities, this medical equivalent grades the stricken people along a single heuristic dimension according to severity of their symptoms and the disability they entail. Classification on these lines has been applied in the largest investigation of somatic illness ever undertaken, namely, the National Health Survey currently being conducted by the United States Public Health Service.[26]

The phenomenal grounds for such categorization of chronic somatic disease have been stated by Sartwell:[27] "Most diseases manifest themselves in a continuous range of severity or extent going all the way from an unrecognizable or sub-clinical level, on to a maximal severity which may be incompatible with life. This range is sometimes referred to as the spectrum of clinical severity." [28]

Karl Menninger and his associates have sketched the historical development of a like classificatory perspective in psychiatry, emphasizing also its recent revival and current usefulness in clinical practice.[29] Summarizing the scientific literature on the etiology of mental disorders, Felix and Bowers conclude that "the trend has been twofold. First, to see mental health and mental illness as *differing in degree rather than in kind* [italics added], and second to take increasing cognizance of the life history and the socio-environmental context of the life history." [30]

From Chapters 3 and 4 it will be remembered that the mental health rating scale on which the Midtown respondents were *finally* placed[31] for purposes of this monograph takes the form of six graded categories of severity of symptom formation. The healthy extreme in this sixfold spectrum is designated *Well,* defined by Rennie's criterion as being free of significant symptoms of mental pathology. Its two adjoining rubrics cover people presenting significant signs of emotional disturbance without apparent constriction or disability in discharging the ordinary functions or roles of adult life. These are designated the *Mild* and *Moderate* categories of symptom formation.[32]

The three categories spanning the morbidity range of the mental health spectrum are all characterized by symptom formations that tend to reflect halting, laming, or crippling effects on the performance of one's daily life roles[33]—in gradient levels now designated *Marked, Severe* and *Incapacitated.* In the interest of verbal shorthand and variety, when it is necessary to discuss respondents of these three categories in the aggregate, we

shall refer to them as the *"Impaired"* or alternatively as the mental morbidity or mental pathology or impairment[34] range of the sample population.

This classification system is patently open to a variety of criticisms. Some of these also apply in varying degrees to psychiatric diagnosis in the clinic setting. Some belong to the perfectionist genre that, in effect, would berate the dancing bear for not pirouetting in the manner of a prima ballerina. One, to be taken more seriously, is that the classification scheme seems to lack any known reference points, and therefore (1) the boundaries of the categories are ambiguous, (2) if not ambiguous, they are arbitrary, (3) and if not arbitrary, they appear to be without anchorage in psychiatric experience.

Actually, Rennie anticipated this criticism, in so far as it was directed beyond the relatively firm anchorage of the Well stratum. The remaining, unconventional categories he related to several more familiar, if nosologically nonspecific, differentiations. In the light of his own extensive clinical experience, both in Baltimore and in New York City, it was Rennie's view that Midtown respondents assigned to the Marked and Severe categories appeared to be symptomatic counterparts of metropolitan patients in ambulant psychiatric treatment. Similarly, he noted that respondents placed in the extreme Incapacitated category had symptomatic counterparts among patients in the Veterans Administration and private psychiatric hospitals he had served. Although he did not make the point explicit, we can infer by exclusion that he probably would have equated the Mild and Moderate categories of the classification spectrum with the subclinical band of symptom phenomena.

It must be emphasized that this calibration by Rennie had not been in the frame of the mental health evaluation process reported in Chapter 4. Rather, it was his own considered, *post hoc* inference drawn from the protocols of the many sample respondents he had himself systematically reviewed as part of a control check on his associates. Nevertheless, the calibration will be recognized for its utility in gearing a relatively new gradient system to a universe of institutionally differentiated orders of treated disability.

It may also deserve mention in the present context that although this classification scheme overlooks important differences in *kinds* of pathology, this fact does not necessarily rule out its potential descriptive or epidemiological significance. Gruenberg, in a similar connection, has pointed out that "there is a vast rage of diagnoses, etiological as well as descriptive, associated with suicide. Yet suicide is a vitally important symptom and many studies attest to the fact that this symptom has epidemiological characteristics rather independent of the distribution of psychiatric diagnoses. The same may be said for juvenile delinquency, alcohol addiction, opium addiction . . . paranoid thinking, phobias,

etc." [35] To Gruenberg's symptom list, the Midtown Study would provisionally add impairment in adult life functioning. Subsequent chapters of this volume will presently bear out that if suicide has certain definite demographic affinities, so also has mental impairment as defined.

A final disclaimer to be recorded is that the Midtown symptom-formation scheme, as it finally evolved, was not altogether an innovation, either in conception or research application. Perhaps the most direct parallel of the Midtown classification is to be found in the postwar studies of psychiatric selection conducted for the Office of Naval Research and reported in a series of papers by C. L. Wittson and W. A. Hunt.[36] Underlying these studies were "three basic assumptions—that emotional adjustment exists on a quantitative continuum . . . that trained psychiatrists or clinical psychologists are able to place an individual in his position on this continuum, and that from this placement valid predictions can be made concerning the individual's future behavior [in the military setting]."

In the research undertaken to test these assumptions,

> . . . the basic design . . . involved samples of [Navy] recruits who came to psychiatric observation during basic training but were subsequently judged able to render satisfactory service and were sent to duty. The psychiatric observation made it possible to classify these men in terms of the nature and severity of their maladjustment. Subsequent survey of their health and service records made it possible to check the accuracy of the classification, using both the criterion of discharge rate and that of incidence of hospitalization. In every study, the validity of the original classifications were confirmed.

Of particular interest is one of the Navy studies in which 944 seamen who had come under psychiatric observation were classified according to degree of maladjustment among three categories, namely, Mild or non-existent, Moderate, and Severe. The independent validity criterion was the rate of neuropsychiatric discharge during the twelve months following. While the over-all psychiatric discharge rate in the Navy was 1.6% per year, the discharge rates for the above three categories were 6.5, 20.2, and 89.7%, respectively.

These results, of course, offer a supporting foundation to the validity of the Navy classification in predicting the outcome of psychiatric discharge. In the case of the more finely divided Midtown scheme of mental health gradations a direct test of its validity would require a follow-up study of our sample respondents and their subsequent development. For a variety of reasons, such an extended longitudinal study is not now within realistic reach. Nevertheless, by the demonstrated validity of their classification system on an independent psychiatric criterion, the Navy studies indirectly reinforce the usefulness that Rennie attached to the parallel system devised and applied in the Midtown Home Interview Survey.[37]

HOME SURVEY SAMPLE: MENTAL HEALTH DISTRIBUTIONS

With this review of the main technical features of the Home Interview Survey, we can now turn to the sample of 1,660 Midtown adults for a first report on their standing within the gradient classification of symptom formation.

Table 8-3. *Home Survey Sample* (Age 20–59), Respondents' Distribution on Symptom-formation Classification of Mental Health

Well	18.5%	
Mild symptom formation	36.3	
Moderate symptom formation	21.8	
Marked symptom formation	13.2	
Severe symptom formation	7.5	
Incapacitated	2.7	
Impaired*		23.4
N = 100%		(1,660)

* Marked, Severe, and Incapacitated combined.

In Table 8-3 we see that roughly 1 in 5 (18.5%) respondents were viewed by the team psychiatrists as free of other than inconsequential symptoms and can be regarded as essentially Well.

The Mild and Moderate categories are the most populous strata (36.3 and 21.8%, respectively), together holding a 58.1% majority of the Midtown sample. It will be remembered that these represent people who to all appearances are performing their adult responsibilities passably or better, although they carry varyingly significant loads of pathology-denoting symptoms. It seems, therefore, that these subclinical strata define the most frequent conditions in the Midtown population, and probably in the inclusive Manhattan white population as well. Whether these are also the most prevalent mental health conditions in more comprehensive segments of the American people is a question rather beyond the capabilities of our data to answer.

Although separately they are the least populated, the three Impaired categories add up to a sizable 23.4% slice of the Midtown respondents.[38] Had we also sampled Midtown's absentee mental hospital patients in the 20 to 59 age range, they would have raised the Incapacitated category (by 0.5%) to 3.2% and the Impaired proportion to 23.9%. Applying the necessary margin for sampling error,[39] we estimate with 95% confidence that in the Midtown population universe the mental morbidity rate stands in a range somewhere between 21.9 and 25.9%. Next, on the basis of our earlier indication that this estimate probably involves an error of understatement,[40] it seems likely that the true rate stands closer to the high point in this range.

With the particular kinds of respondent data that were secured, the symptom-formation classification could be readily applied by the Study's psychiatrists. For reasons already discussed, such confidence could not be extended to classification of sample respondents in terms of the established psychiatric nomenclature. Nonetheless, at the beginning of the evaluation process the ultimate workability of the symptom-formation mode of classification was still uncertain. In short, it entailed an unknown risk of losing invaluable, irreplaceable time. As a form of insurance, therefore, Rennie instructed the evaluating psychiatrists to apply as best they could a second, supplementary classification system, designated the *gross typology*. This involved nosological categories familiar in psychiatry, but their qualification with the term *probable* (more strictly speaking: *possible*) reflects the recognition that they were based on a very large leverage of psychiatric impression and intuition applied on a fulcrum of data not designed for this purpose. With the utility of the symptom-severity rating system subsequently established, the reserve use of the gross typology scheme is obviated in this volume. However, we yield one exception at this point, for whatever suggestive value there may be in sensing the diverse make-up of the impaired group as delineated under the symptom-formation mode of classification. Thus, analysis of the gross typology composition of the sample's 389 Impaired respondents suggests that about 1 in 20 (5.7%) falls in the probable organic (damage or deficiency) type, 1 in 4 (26.5%) in the probable psychotic type, and the remaining two-thirds (67.8%) in the probable neurotic or probable personality disorder types. Of course, the latter two types are concentrated most heavily in the Marked category of symptom formation.

MENTAL MORBIDITY RATES AND CRITERIA IN OTHER STUDIES

The 23.4% impairment rate found in the noninstitutional, in-residence sample population of Midtown may be viewed by some students as staggering in magnitude, and of dubious credibility.

We must address ourselves to such skepticism as potentially justifiable. Specifically, the credibility of the finding may be questioned on two different planes. On one level, the question may imply that the morbidity rate reported is beyond serious technical reproach, but the study population in its loading of mental pathology may be an extreme, local deviant on the American scene. On another level, the study population may not be grossly atypical, but the Midtown psychiatrists' criterion of mental morbidity could be faulty in its excessive breadth.

To get purchase on the first level, a nationwide study of mental health applying the Midtown classification of symptom formation, is lacking to us. However, the Midtown interview instrument included a series of

"signs and symptoms" questions that had previously been used in the development of the Army's Neuropsychiatric Screening Adjunct questionnaire. Toward this development in 1944, a cross-section control sample of 3,501 white enlisted men on active duty, with no overseas service (and almost entirely between the ages of 18 and 36), anonymously filled out the experimental questionnaire. Compared to the Midtown sample, this Army sample was of course more homogeneous in age, sex, and socioeconomic status, more heterogeneous in rural-urban and regional origins, and in general more representative of the white population in the nation at large.

Despite these differences, if Midtown adults in mental health respects are an atypical population, we would expect them to show consistently larger frequencies of specific pathognomonic signs than did the Army sample. For purposes of this comparison we have confined ourselves to the 18 symptom questions that were used in both studies with identical wordings. Only in two of these items did the Midtown sample appreciably exceed the Army's frequencies of "symptom positive" answers. On eight questions, it was the Army sample that exceeded Midtown's in this respect. And in eight other items, the two samples were more or less identical in their replies. Particularly significant in the latter series was the query: "Are you ever bothered by nervousness?" "Yes, often" rejoinders were given by 17% of the Army men and by 18% of the Midtown respondents.

Nothing can be extracted from this limited analysis to support the inference that the Midtown population is any more deviant than the comparison population of relatively selected,[41] able-bodied, young, white enlisted men. A lesser but related clue may be offered by the 2,252 New Yorkers who applied for treatment to a new, unopened, low-cost psychiatric clinic. Scattered through the five boroughs, they comprised a city-wide rate of 26 per 100,000 population. Midtowners among these applicants represented an area rate of 23 per 100,000. In this expressed need for psychiatric help, Midtown hardly appears atypical of New York City at large.

A second basis for questioning the magnitude of the Midtown impairment rate can turn on the possibility that the criterion of mental morbidity it reflects was stretched beyond resemblance to clinical realities. Rennie's calibration of the Midtown impaired categories to the out-patients and hospital patients in his metropolitan experience lessens this specific possibility.

The skeptics can insist, nonetheless, that the Midtown morbidity rate is out of line with previous knowledge, drawn principally from studies of patients. Even more to their case, they can point to two other studies involving professional evaluation of mental health in a large metropolitan sample and producing morbidity rates patently well below that of Mid-

town's in both cases. One of these was the investigation in Baltimore conducted by the Commission on Chronic Illness.[42] The other was the wartime study of Selective Service examinees in the Boston induction station, as reported by Hyde and Kingsley.[43]

To meet such evidence it is possible, of course, to marshal counter-indications, e.g., the various estimates that 10 to 50% of patients seen by general practitioners and internists are "psychiatric cases." [44] Or there is the morbidity rate of 32% uncovered in a Salt Lake City sample of 175 households, by methods exemplifying rather less than the most advanced standards of sampling.[45]

Even if these rates were defensible, however, they would still be irrelevant to the challenge offered the Midtown Study by the Baltimore and Boston investigations, to which we must now detour for careful examination.

The Baltimore investigation consisted of three different research operations, the only one of pertinence here being that designated the *clinical evaluation.* Focused on a broad spectrum of chronic and acute somatic illnesses, and also mental disorder, this particular operation started with a drawn sample of 1,292 persons in an age range defined as reaching from "under 15 to over 65." Of these, 809 individuals, or 62.6% all told, appeared in clinic for (1) a battery of laboratory tests and (2) thorough physical examinations by one of a staff of 31 physicians, internists in the main. From this sample of participating examinees a "weighted" estimate of 10.9% was derived as the prevalence rate for mental disorder.[46] This figure has not only been extrapolated to the city of Baltimore and quoted in Federal publications addressed to the general public, but in a variety of publications has also been projected on the American population at large.

The basic fact that need concern us here is that between the reported Baltimore mental disorder frequency of 10.9% and Midtown's 23.4% impairment rate stretches a seemingly unbridgeable gulf. Before we accept this difference as lending credence to views that the Midtown Study's criterion of mental morbidity was overextended, we must first determine whether the two studies are comparable in other relevant respects.

First, the studied populations are far from demographic comparability, but this can be partially corrected by isolating the segment of the Baltimore sample that most nearly matches the Midtown respondents, at least in race and age composition. The closest Baltimore age approximation reported in the source volume[47] is the 15 to 64 age range, where the morbidity frequency is 14%. We are not told the disorder rate for examined sample people of this age span who are white, numbering 371 individuals. However, we are told that for the whites of all ages the morbidity rate is almost three-fourths again higher than for nonwhites. Setting aside the nonwhites brings the mental illness frequency among the indicated sub-

sample of 371 white persons, by our calculation, to about the 16% point.

Attention is next drawn to the Baltimore classification process. For one thing, the complete examination in clinic was made by internists (rather than psychiatrists), who had many somatic conditions to check systematically and apparently were short both in clinic time for focused psychiatric inquiry and in prior training for secure psychiatric observation, reporting, and evaluation. Explicit at least is that the Baltimore mental disorder rate is beset with potentially serious problems of underreporting, as the monograph authors are at some pains to indicate in the following passages:

1. It was recognized that the number of cases of a particular disease uncovered is closely related to the thoroughness of the examination.[48]

2. With a large number of physicians participating . . . it was not feasible to develop rules governing the recording of diagnoses. . . . The physicians were therefore asked to record all conditions, acute or chronic. . . . Under this general directive there was, as anticipated, a very wide variation in the kinds of conditions which physicians recorded [and presumably did not record] as diagnoses.[49]

3. The method of arriving at diagnoses probably is a more significant factor [affecting] the prevalence [rate] of mental disorders than . . . most other diseases discussed in this report. The examining internists diagnosed a mental disorder as they chose, with or without a psychiatric consulation or psychometric testing.[50] It was recognized that there would be differences in physicians' *interest in and willingness to diagnose mental disorders.* The records, therefore, were subsequently reviewed by a psychiatrist and classified by diagnosis and severity of impairment. . . . In this review, there became apparent substantial differences among examining physicians in the *completeness of recording of information* bearing on mental disorders. The review resulted in the deletion of about one-third of the cases which had been diagnosed [as mental disorders] by examining physicians, on the basis that the information *recorded* did not adequately support the diagnosis. To the extent that the deletion of cases by the reviewing psychiatrist was due to *incomplete recording of evidence* by the examining physician, the data presented here *understate the prevalence* [all italics added].[51]

Thus, in the Baltimore clinical study, the recording of psychiatric diagnoses and supporting evidence depended entirely upon the motivations of the examining internists to venture a diagnosis beyond their professional competence and, if they so ventured, to inscribe the evidence in sufficient volume and detail to satisfy the specialized and exacting, but previously undefined, criteria of the reviewing psychiatrist.

Under these circumstances, it appears likely, first, that cases of mental pathology in the Baltimore sample examined went unrecognized by the physician, or, if recognized, were unrecorded. Their number is of course unknown. Second, among the many cases of recorded pathology that were subsequently rejected by the reviewing psychiatrist, it is likely that

a number reflected inadequate probing for or recording of supporting details, rather than absence of mental illness. On the base of a 16% mental morbidity rate above derived for the subsample of Baltimore age 15 to 64 whites, we can estimate that prior to such review and rejection this morbidity rate stood at about 24%.[52] Represented in the latter rate would be the "false positives" correctly rejected by the reviewing psychiatrist, but *not* the "false negatives" that were overlooked or maldiagnosed or left unrecorded by the examining internists (and unreviewed by the reviewing psychiatrist). If these two different kinds of errors should happen more or less to cancel each other out, a matter on which evidence is lacking, the estimated 24% morbidity rate would seem to stand as approximately accurate.

The original mental disorder rate of 10.9% reported for the Baltimore sample examined in clinic appears to be distant indeed from the Midtown sample finding of mental impairment in a frequency of 23.4%. We have now demonstrated that the apparent discrepancy between the two studies is not real. When the Baltimore sample is demographically matched to the Midtown sample, the illness rate, on evidence reported, must be adjusted from 10.9 to 16%. And if identifiable errors of underreporting and overreporting of mental pathology should balance out, it appears possible that the true frequency might approach 24%, or near identity with the Midtown rate.

However, any Baltimore frequency would suffer from the further damaging fact that 44% of the Baltimore sample whites originally selected for clinical examination did *not* participate in the study.[53] With so large a defection, the bias potential in the studied sample itself is serious indeed. The Baltimore investigators' method of applying "weights" in an effort to compensate for observed biases in age, sex, and racial composition[54] altogether fails to correct for the possibility that participants in the underrepresented groups may be unrepresentative of the many nonparticipants on the crucial index of mental pathology rate. Specifically, if the mentally ill predominantly chose not to submit to the requested medical examination in clinic, then the 24% morbidity frequency estimated above as possible—for the Baltimore age 15 to 64 white subsample actually studied—may be an understatement by a considerable margin. All in all, in the face of this haunting unknown, it must be submitted that the Baltimore mental disorder rate is altogether too inconclusive to be used in judging the tenability of the mental morbidity finding of the Midtown Study.

A more promising bench mark may be elicited from America's World War II experience with military-age men. In the most comprehensive review of that experience made available to the date of this writing, Brill and Beebe[55] focus on "the manpower pool of about 26 million men who were in the ages 18–37 in 1941, plus those reaching their 18th birthday

in the succeeding four years." The quoted authors divide this pool of men into three segments: (1) served in Armed Forces, (2) medically disqualified for such service, and (3) granted occupational or other deferment from such service. For each segment they estimate the prevalence of "psychoneurosis, pathological personality and other psychiatric disorders" and "psychiatric defects, mental or educational deficiency." In the three indicated segments, these total 4.7 million men (excluding the category "neurological defects") or 18.1% of the entire pool.

This datum, of course, refers to the entire national population of military-age men. A closer match to the Midtown male population can be drawn from wartime Selective Service rejections on psychiatric grounds at the well-documented Boston Regional Induction Station.[56] Relative to all examinees, we know that the station's psychiatric rejection rate was 10.6% during the early months of the war[57] and 21.3% in August, 1945.[58]

We also know that the national psychiatric rejection rate fluctuated appreciably through the war years with shifts in standards and military demands for manpower. We can assume that the Boston station's rate fluctuated similarly, probably around 16%—the middle point in the above range. On the basis of a 1942 study of the station's examinees we can adjust this median rate to about 17.5% for white men from the high-density areas of metropolitan Boston. If we could also take into account the unrecorded psychiatric cases screened out *before* reaching the station's examiners, and also the subsequent recorded and unrecorded psychiatric discharges from the armed services, the over-all rate would almost certainly turn out to be not less than 20%.

To achieve a better-fitting match to this military-age, white Boston population, we might look at the age 20 to 39 males in our Midtown sample. And there we find an over-all prevalence of impairment in a frequency of 19.5%. The chances are 95 in 100 that this rate stands somewhere between 15.1 and 23.9% in the corresponding segment of the Midtown population universe.

We would not be understood to attach any large significance to the seeming concordance between the Boston frequency of mental morbidity, as just worked out, and Midtown's. It is universal knowledge that initial Selective Service psychiatric examination was usually brief and superficial, and evaluation was hardly geared to a realistic formulation of psychological balances required to cope with the military environment. From the viewpoint of military manpower needs, therefore, such screening may have discarded too many men who could have been fitted to a limited service function of some kind. However, its very superficiality and an accompanying set of intense social pressures for acceptance in the armed forces, together argue that few of these men could have been

rejected except on psychiatric grounds that were sufficiently telling by the criteria of civilian experience.[59]

From this comparison of the Baltimore, Boston, and Midtown data we do *not* draw the inference that *over-all* mental morbidity rates in the three populations were demonstrably alike. Although we made several adjustments in the data to enlarge comparability, remaining uncontrolled are several large intercommunity variations: (1) known differences in such elements of demographic composition as socioeconomic standing and ethnic origin—which could not be analytically controlled because of lack of necessary information; (2) known gross differences in the operating circumstances of the psychiatric examination and evaluation process; and (3) probable differences in professional criteria for differentiating the mentally ill from others. On all these counts, it remains impossible to make any generalizations about relative magnitudes of *over-all* mental pathology in the three analyzed populations.

Nonetheless, we have introduced the two comparison populations to suggest, despite appearances to the contrary, that they offer no evidence to support a view of the Midtown mental morbidity rate as out of line with previous relevant research experience.

HELP-NEED AND READINESS

Earlier in this chapter we fixed attention on the results of our Treatment Census operation. There, numbers of patients in therapeutic facilities were expressed as rates per 100,000 of the general population. We found that these rates cannot be accepted as reliable indicators of *over-all* frequency of mental morbidity in that population, primarily because limited local treatment capacities place an artificial ceiling on the number of sick people who can be accommodated as patients.

Yet this very factor of number of patients remains of intrinsic interest in its own right as a portal to a logistic problem in the distribution of treatment resources. To this end, it will be more useful if expressed as a rate relative not to the community population at large, but to the group at risk of requiring help, or more precisely, in this instance, the disability group in presumptive need of professional intervention. About this latter group the Treatment Census data could, of course, tell us nothing.

Fortunately, the Home Survey can speak to this point, in the specific form of the 389 sample adults, age 20 to 59, who fall within the Impaired range of the psychiatrists' mental health gradient scheme. On the criterion of observed or inferred performance deficiencies in adult roles, these people in most cases can be assumed to need professional help of some kind, at best, to relieve the distress implied by their symptoms and to improve their capacities for adult functioning, and at the least, to

reduce possibilities of future deterioration under normal or crisis circumstances of life.

On the whole, therefore, we have warrant to translate the Impaired group into the broad category of *help-need.* It is hardly necessary to add that such inferred need is not circumscribed by the impaired individual, but includes as well his family, friends, work associates, employer, and the community itself, who all stand to be helped in some large or small measure by his improvement. In relation to the hobbled individual at the center of this social circle, "help" is not necessarily equated here with individual, intensive, long-term psychotherapy. For many, such treatment may not be specifically indicated, and for most, given such insurmountable realities as high costs and insufficient therapists, it is not remotely possible. Alternative kinds of professional help are still in the crawling stage of development, but it can be assumed that under pressures of acute necessity inventions not yet envisaged will presently emerge. As one example, Sanford[60] perceptively argues "for research on the communication of mental health information. Maybe we can find a way for the gifted analyst to affect the lives of 15,000 people rather than the 150 people who now occupy his professional lifetime."

In any case, we can here empirically address ourselves only to two small but important facets of the over-all problem of help-need. First, we can ask the extent to which the individuals in the impaired range within the Midtown sample have ever been in the status of psychiatric patient. This was put to *all* sample respondents as follows: "We are also interested in the kinds of medical specialists people go to. Have you ever gone to any of these specialists?" Seven kinds of specialists were separately named for a yes or no reply. Fourth and fifth on this list were "nerve specialist" and "psychiatrist." [61]

All told, 222 respondents, or 13.4% of the entire sample, had been to one or more psychotherapists.[62] Respondents indicating they had been patients in this sense were asked only one follow-up question, inquiring when they had last been to the therapist. Where the last contact had been as recent as a month before the interview, the respondent was classified as a current patient; all others, somewhat arbitrarily, as ex-patients. On this criterion, 40 respondents were patients and 182 were ex-patients, or 2.4 and 11% of the sample, respectively.[63]

It must be emphasized that the classification of both types of patients is ambiguous on an important point. That is, at one extreme are those who may have seen a therapist for consultation or diagnosis only, with no subsequent treatment, and at the other extreme are those who may have been in treatment for years. Nevertheless, although a patient history in any particular case cannot necessarily be equated with exposure to treatment, in all cases it does seem to reflect the twin minimal facts that the need for seeing a psychotherapist was felt and acted upon.

In Table 8-4 we report the distribution of each Impaired grade on the patient-history variable. Among the separate impairment groups the differences in ever-patient rates are relatively small, ranging from about 1 in 4 (23.3%) of the Marked group to about 1 in 3 (35.5%) of the Incapacitated.

Table 8-4. *Home Survey Sample* (Age 20–59), Impaired Respondents' Distributions on Patient-history Classification by Impairment Grades

Patient-history	Impairment grades			
	Marked	Severe	Incapacitated	Combined Impaired
Current out-patients	5.0%	4.0%	11.1%	5.4%
Ex-patients	18.3	25.6	24.4	21.3
Ever-patients*	23.3	29.6	35.5	26.7
Never-patients	76.7	70.4	64.5	73.3
N = 100%	(219)	(125)	(45)	(389)

* It must not be inferred that respondents who were ever-patients were necessarily considered by Study psychiatrists as being in an Impaired state of mental health. On the contrary, of the sample's 40 current out-patients, 19 were not so regarded. And of 182 ex-patients, 99 were not so considered.

If we conceive of the Impaired respondents in the aggregate as metaphorically approximating the form of an iceberg, then only one-twentieth (5.4%) of this mass is in any one month visible, however briefly, to psychotherapists in ambulatory facilities.[64] In addition, about one-fifth (21.3%) had once come to such professional attention, in some instances within hospital settings, but are still in a help-need condition. Finally, about 3 in every 4 (73.3%) of these Impaired people are the completely "submerged," having never been known to any psychotherapist.[65] Here sketched for the first time, we believe, in any American population is the patient-history structure of one community's mass of mental morbidity. This structure takes the roughly delineated form of a pyramid, by far the largest part at the base never having found the way to a psychotherapist for a single session of consultation, and a small fractional part forming the peak currently visible to psychiatrists.

Of the former, we have no information revealing whether they are receiving need-directed help from other kinds of professionals. However, we did approach the entire Midtown sample for orientations to several relevant types of professional assistance. This was probed indirectly by means of two mental illness problems posed in terms of advice solicited by hypothetical friends: (1) "We are interested in what people think about ways of handling family problems. Now let's suppose some friends

of yours have a serious problem with a child. I mean a problem with the child's behavior, or difficulty getting along with others. The parents ask your advice as to what to do. What would you probably tell them to do about it?" (2) "Now let's suppose a good friend [same sex as respondent] came to you about serious trouble in his [her] marriage. He [she] asks your advice as to how to straighten it out. What might you tell him [her] to do about it?"

We have classified respondents in one of four categories: (1) those who, to either or both of the two questions, advised seeing a "psychiatrist" or a "psychologist" or their institutional equivalents; (2) all others who to either question advised "see a physician" or his institutional equivalent, e.g., a pediatric clinic; (3) those remaining who to either question advised seeing some other remedial professional person, e.g., a clergyman or social worker; (4) the residue of those whose reply in *both* situations failed to include any suggestion of professional help.[66]

The above two life-problem questions were open-ended, giving no hint themselves of the possibility of professional help as such. Since they left the respondent a wide range of action alternatives to choose from, we can be reasonably confident on this point: Those respondents who would specifically recommend a psychotherapist to a friend under these circumstances are probably in a state of potential readiness to apply such advice to themselves.

The results among the sample's Impaired never-patients are seen in Table 8-5.

Table 8-5. *Home Survey Sample* (Age 20–59), Impaired Never-patients' Distribution on Professional Orientation Variable

Current patients	5.4%
Ex-patients	21.3
Never-patients (73.3%) advising:	
"See psychotherapist"	13.4
"See physician"	8.5
"See other professional"	7.2
No professional advised	44.2
N = 100%	(389)

Returning to the entire Impaired group in Table 8-5, only 1 in 20 (5.4%) is presently in a patient role with a psychotherapist, and in this specific sense is in an active state of seeking the most appropriate professional help for his need. These will not concern us further in the following discussion.

Another 1 in 5 (21.3%) of these Impaired respondents has been in this patient role and presumably has seen it terminated. Relative to the psychotherapeutic professions, therefore, he is currently in an inactive

status. However, on the criterion of his previous activity we can assume that henceforth he will find his way to a psychotherapist more readily than others in need of such help.

Of the entire Impaired group, another 1 in 8 (13.4%) has never been in the role of a psychiatric patient but appears to be disposed to accept it. If potential demand for psychotherapy of some kind can be defined as "need combined with willingness to accept such help," [67] then these never-patients and the ex-patients appear to be the closest, albeit crude, approximation we can reach to an estimate of the extent of such unmet potential demand. Together, these constitute 34.7% of the Impaired respondents and 8% of the entire interviewed sample.

Of all the Impaired people, 15.7% are never-patients who, we can infer, are either getting help from a physician or other professional, or are inclined to seek such help from these specialized directions. Finally, a little under half (44.2%) of the Impaired group are never-patients who appear to give no sign of orientation to professionals as a possible source of assistance. These seem to represent the large segment of help-needy who are unlikely to come to psychiatric attention, at least of their own initiative.

Among all the help-needy people, therefore, we can judge that the unmet potential demand for psychotherapy of some kind is relatively large. But even larger in number are those who, for a variety of possible reasons, apparently perceive no professional person or agency as haven of possible relief for the disability and distress they suffer in their daily lives.

The dimensions of the social problem disclosed by these two Impaired subgroups are indirectly suggested by this glaring fact: the small summit-of-pyramid subgroup now seeing a psychotherapist is by itself sufficient to "strain the seams" of psychiatric resources to their utmost in the metropolis with by far the largest ambulatory treatment capacities, relative to population, in the entire country. In light of this fact, policy problems of enormous proportions seem to be posed by the extent of potential demand for professional intervention here crudely estimated.

Some may find it comforting to escape these problems by rejecting the technical grounds on which the estimates rest. Strictly speaking, this is an empirical question, of course, that further research alone can answer in due time. In the meantime, however, if only the Incapacitated and Severe symptom-formation grades in the Impaired range are considered as warranting psychiatric help, the problem of meeting their unserved needs would still be pressing and huge in magnitude.

Despite the thick hedge of qualifications that surrounds the Midtown morbidity and nontreatment findings, these estimates suggest reconsideration of the entire strategy of confronting and relieving the mass of mental

pathology prevalent in the population. Such reconsideration of public policy cannot be denied except at peril to the sick, to the healing professions, and to the community at large.

SUMMARY

1. On the yardstick of a one-day prevalence count, the Treatment Census found that in-patients hospitalized continuously for up to five years constituted 502 per 100,000 of the total Midtown population. Average length of hospitalization among these patients in public institutions is more than twice that of their counterparts in private hospitals. However, to judge from readmission cases, the frequency of relapse and rehospitalization is no different in the two patient groups.

2. On the same prevalence yardstick, 788 per 100,000 of the entire Midtown population were reported as ambulant mental patients in clinic or office facilities. Evidence was noted warning against the inference that patient status, hospital or ambulant, necessarily indicates therapy was involved.

3. Contrary to previous assumptions, a substantial proportion of patients diagnosed as psychotic are in ambulant treatment facilities. Accordingly, hospitalization rates as used in previous studies must be rejected as an index of frequency either of total psychoses or of *treated* psychoses in an urban community population.

4. A difference of approximately 4:1 between Midtown and New Haven in reported prevalence of ambulant nonpsychotic patients can be largely attributed to intercommunity differences in out-patient treatment capacities, rather than to over-all frequency of such conditions. A supply-demand principle consistent with these data was formulated.

5. Both the Midtown and New Haven populations are more favored than the rest of the country in their supply of psychiatric clinics and office therapists. Yet there is ample evidence from both places that this supply was insufficient in the period of study to the local demand for such services. Under such bottleneck circumstances, therefore, patient rates can only reflect the supply of therapists locally available, rather than the *over-all* frequency of mental morbidity. In an attempt to measure the latter, the Home Survey was conducted in a random sample of the general population of Midtown ranging between the ages of 20 and 59. All subsequent points in the present summary refer to results of this survey.

6. As a prelude to its findings, the methods of the Home Survey were recalled. Particular attention was paid to the psychiatrists' mental health classification of survey respondents, and the issues it raises for methodologists, both in social science and psychiatry.

7. In the survey sample, an impairment rate of 23.4% compares with a Well frequency of 18.5% and a combined Mild-Moderate representation

of 58.1%. Two forms of skepticism may be directed against the 23.4% morbidity rate. The first questions whether Midtown, in mental health respects, may not be a deviant population on the national scene. However, on a series of pathognomonic signs and symptoms, covered both with the Midtown respondents and a national cross-section sample of white Army men, there appeared few differences to lend credence to this possibility.

8. A second question suggests that the Midtown morbidity range may be excessively broad relative to clinical standards. Evidence seemingly supporting this possibility is marshaled from investigations of the Baltimore and Boston populations, both presenting mental pathology rates well below that of Midtown. Close analysis of data from these two studies revealed that their deviations from the Midtown morbidity rates were not real. Accordingly, they fail to support the hypothesis that the Midtown psychiatrists' definition of mental morbidity may have been overextended in its scope.

9. Focusing on the Impaired category of sample respondents, it was assumed that they were in a state of professional help-need. Of interest was the extent to which these respondents had ever seen a psychotherapist, our criterion for a patient history. Among these Impaired people in the aggregate, only 1 in 20 could be considered a current patient. Another 1 in 5 were ex-patients, and roughly 3 in 4 had never come to the attention of such a specialist.

10. On the criteria of impairment and readiness for professional help, we discerned a large potential demand for such intervention. Even more numerous, however, were the Impaired never-patients who seemed unlikely of their own accord to find a way to professional help of any kind.

11. These data pose challenging questions about the community's strategy of marshaling professional services for the help-needy.

FOOTNOTES

[1] Excluded were specialized institutions for mental defectives. Also, at the suggestion of Dr. Henry Brill of the New York State Department of Mental Hygiene, patients hospitalized continuously for five years or more were not counted in our Treatment Census. Dr. Brill at that time pointed out that the chances of such a patient leaving the institution alive were slight. Even if he should be discharged after so long an absence the patient's local ties to family and extrafamily associates, frayed or broken at the time of hospitalization, would probably be moribund through attrition, death, removal to another area, etc. (See N. C. Morgan and N. A. Johnson, "Failures in Psychiatry: The Chronic Hospital Patient," *Am. J. Psychiat.*, vol. 113, no. 9, pp. 824–830, March, 1957.) Accordingly, for a section of a metropolis like Midtown such patients can no longer be meaningfully considered as among its bona fide residents.

In the absence of any evidence available at the time, we assumed that the number of plus-five-year patients so excluded would not be excessively large. However, a subsequent study in the state hospitals of seven states (New York excluded) and a separate study in the New York state hospitals revealed that of all patients in these

institutions on a given day about 60% had been continuously hospitalized for five years or more. Accordingly, it is almost certain that the plus-five-year patients uncounted by our Treatment Census are numerous indeed. As to Midtown's private hospital patients, none had been continuously confined for more than three years.

[2] It must be emphasized that the Treatment Census operation was conducted in a period before the introduction of tranquilizing drugs. Of course, these have since reduced average length of hospitalization. Even in this later period, however, of all patients in New York state hospitals about 3.5% received active psychotherapy, 15% drug treatments only, and 81.5% custodial care only. (Dr. Paul Hoch, report to Milbank Memorial Fund Technical Board, Mar. 20, 1956.)

[3] In the New York state hospital system as a whole, one-third of all discharged patients relapse and are returned to a state institution (*ibid.*).

[4] Throughout this volume, the term *clinics* will be used to refer exclusively to psychiatric out-patient clinics.

In the official "1954 Directory of Psychiatric Clinics in New York State," 77 out-patient clinics were listed in Manhattan; 13 others were identified in the borough through local sources. About one-third of these clinics serve the home borough alone, the remainder serving the entire city.

[5] Within the boundaries of New York City, residents of the four outer boroughs can secure professional services either in the home borough or in Manhattan. Geographically dispersed in the outlying boroughs, such services are highly centralized in Manhattan. Thus, the Manhattan resident is most unlikely to seek these services in the outer boroughs. This pattern was preeminently the case for ambulant mental patients. Accordingly, our Treatment Census could safely concentrate its coverage on office therapists and clinics in Manhattan only.

[6] Some 11% of these Midtowners were in the care of clinical psychologists.

[7] The method of deriving this estimate was as follows: (1) The cooperating therapists were divided into four groups according to (*a*) psychiatrists versus psychologists and (*b*) offices in or near the Midtown area versus those more distantly located in Manhattan. (2) We calculated the average number of Midtown census day patients reported by each of the above four groups. (3) We divided the noncooperating therapists into the above four groups and assumed that each of the four would have reported patients approximating the average reported by the corresponding group of cooperating therapists. (4) On this basis, it is calculated that the noncooperating therapists would have designated an additional 127 patients, to produce an estimated total of 1,086 private office patients.

For reasons we need not take space to explain, we believe that another large source of error is traceable to the underreporting of cases on the part of an unknown number of *cooperating* psychiatrists and psychologists. However, no attempt will be made here to correct for this particular source of error, since we lack any basis for estimating its magnitude. The reader will take into account this potentially large error of understatement.

[8] A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness,* 1958. The total New Haven population figure used as denominator in calculating the rates is 236,940 and appears on p. 199 of the latter monograph. A total of 1,963 New Haven patients were enumerated, but 72 were of unknown social class position. (A. B. Hollingshead and F. C. Redlich, "Social Stratification and Psychiatric Disorders," *Am. Soc. Rev.*, vol. 18, no. 2, p. 167, April, 1953.) Elsewhere it is reported that of these 1,963 New Haven patients, 159 were found in clinics and 374 were in the care of private psychiatrists. (B. H. Roberts and J. K. Myers, "Religion, National Origin, Immigration and Mental Illness," *Am. J. Psychiat.*, vol. 110, no. 10, p. 759, April, 1954.) These are the numerator figures used in computing the New Haven rates appearing in our Table 8-2.

[9] Through the checking of our records for instances of the same patient being reported by several treatment facilities, we believe this total to be free of error from such duplication.

[10] *Annual Report for Calendar Year 1957,* Biometrics Branch, National Institute of Mental Health, p. 10.

[11] *The Functioning of Psychiatric Clinics in New York City,* New York City Committee on Mental Hygiene, 1949.

[12] The New Haven proportion has been calculated from distribution data in Hollingshead and Redlich, *op. cit.,* p. 258.

[13] From the Midtown Treatment Census there is reason to believe that the cooperating office therapists in an unknown number of instances were unwilling to report a psychotic patient or to attribute a psychotic condition to a reported patient. If so, these figures relating to both the Midtown and New Haven out-patient populations may be in error on the side of understatement.

[14] Compared to the North, Southern states generally have low in-patient rates. One factor contributing to this difference is that a state like New York admits Negroes to its extensive mental hospital system without apparent discrimination. In Southern states, relatively few Negroes are hospitalized because the necessary facilities simply are not provided. (Cf. B. Malzberg, "Important Statistical Data about Mental Illness," in S. Arieti (ed.), *American Handbook of Psychiatry,* 1959, vol. I, p. 171.

[15] This rate has been computed from data in Hollingshead and Redlich, *op. cit.,* p. 258.

[16] At the time of the New Haven investigation there were no clinical psychologists known to be in private practice within its study area (personal communication from Fredrick C. Redlich).

[17] It is also of interest that of the 4,000 psychiatrists in the United States estimated by Clausen as engaged in private practice (during 1954), fully 20% by our calculation conduct that practice on the Island of Manhattan and about 2% more in the rest of New York City. Approximately half (53%) are practitioners in *all other* American cities exceeding 100,000 people and about 25% serve all other American places with populations under 100,000. (J. A. Clausen, *Sociology and the Field of Mental Health,* Russell Sage Foundation, New York, 1956, p. 9.) Whether this unbalanced distribution is in the public interest constitutes a policy question outside the province of this report.

[18] Between 1947 and 1957 the number of A.P.A. members in private psychiatric practice grew from 5 to 27 in New Haven and from 330 to 910 in Manhattan. No comparable data are available for clinical psychologists in private practice. However, there are some indications that their rate of growth in Manhattan during this decade may have been faster than that of the psychiatrists.

[19] Hollingshead and Redlich, *op. cit.,* p. 154.

[20] *Mental Health Facilities and Needs in New York City,* Welfare and Health Council of New York City, 1956, p. 6. That this situation was still chronic three years later is revealed in a report by the Community Council of Greater New York (*Welfare and Health in New York City: 1959,* p. 30). Indicating that "both children and adults find extremely long waiting periods before they obtain service," the report added: "It is ironic, but the only sure way to get prompt psychiatric treatment is to sit on a lofty window ledge and threaten to jump."

[21] J. A. Clausen, "The Sociology of Mental Illness," in R. K. Merton et al. (eds.), *Sociology Today,* 1959, p. 494.

[22] E. Gruenberg, "Problems of Data Collection and Nomenclature," in C. H. Branch et al. (eds.), *The Epidemiology of Mental Health,* 1955, p. 68.

[23] E. Gruenberg, "Epidemiology of Mental Disorders," *Milbank Mem. Fund Quart.,* vol. 35, no. 2, p. 121, April, 1957.

[24] The social scientist working in psychiatry is aware that some therapists, especially those somatogenic in emphasis, regard the major syndromes of mental illness as more or less distinct disease entities. However, he also hears an impressive chorus of psychiatric dissent from this view. For example, Karl Menninger has commented: "I not only believe that no such disease as schizophrenia can be clearly defined or identified or proved to exist, but I also hold that there is no such thing as a psychosis or neurosis. My point is that no one can satisfactorily define these terms in a way which the rest of us can accept, so that if we use the terms we involve ourselves in confusion." (Karl Menninger, "Toward a Unitary Concept of Mental Illness," in *A Psychiatrist's World,* 1959, p. 517.) For further manifestations of Freud's impact

on the concept of mental disease entities, see P. Hoch and J. Zubin, *Current Problems in Psychiatric Diagnosis*, 1951, to which Rennie contributed a notable paper, "Prognosis in the Psychoneuroses," pp. 66–79.

[25] Clausen, *op. cit.*, p. 493.

[26] United States National Health Survey, *Preliminary Report on Disability, United States, July-September, 1957*, pp. 6–8.

[27] P. E. Sartwell, "Problems of Identification of Cases of Chronic Disease," *Milbank Mem. Fund Quart.*, vol. 31, no. 3, p. 17, July, 1953.

[28] To these phenomena others have applied the concept of biologic "gradient of disease." See John E. Gordon, "The World, the Flesh and the Devil as Environment, Host and Agent of Disease," in I. Galdston (ed.), *The Epidemiology of Health*, 1953, p. 70.

[29] K. Menninger, "Toward a Unitary Concept of Mental Illness," in *A Psychiatrist's World*, 1959, pp. 516–528.

[30] R. H. Felix and R. V. Bowers, "Mental Hygiene and Socio-environmental Factors," *Milbank Mem. Fund Quart.*, vol. 26, no. 2, p. 130, April, 1948.

[31] That is, after systematic adjudication of cases in which the two psychiatrists differed in their independent evaluations. The method of adjudication was adapted to the degree of difference in judgment expressed by the two psychiatrists in rating the mental health of a given respondent. If the latter had been placed in adjoining mental health categories, he was regularly assigned to the *more favorable* of the two categories. If in certain instances he was placed in categories two steps apart, he was systematically placed in the *intervening* mental health grade. And if in a few cases he had been placed in categories three grades apart, then Rennie reviewed the respondent's data and with his associates made the final determination.

[32] Because the line between these two categories involved for the psychiatrists a more-less kind of differentiation and in practice was difficult to draw with sufficient agreement, we can hereafter discuss them together when convenient to do so.

[33] The parallel criterion being applied in the National Health Survey is "morbidity measured along an axis for which the scale is in terms of the effect that the morbidity has upon the lives of the people concerned." (See United States National Health Survey, *Concepts and Definitions in the Health Household-interview Survey*, 1958, p. 1.)

[34] In this context, therefore, "impairment" does *not* refer to organic damage or deficiency, although conditions of this nature were documented or seemed probable among a few interviewed respondents, constituting 1.7% of the entire sample.

[35] Gruenberg, *op. cit.*, p. 122.

[36] "The Predictive Value of the Brief Psychiatric Interview," *Am. J. Psychiat.* vol. 107, pp. 582–585, February, 1951; and "A Rationale for Psychiatric Selection," *Am. Psychologist*, vol. 10, no. 5, pp. 199–204, May, 1955. See also the extensive work on a health-sickness scale conducted by the Menninger Foundation, L. Luborsky and H. Sargent, "The Psychotherapy Research Project," *Bull. Menninger Clin.*, vol. 20, pp. 263–276, 1956.

[37] Our Treatment Census enumeration represents prevalence of patients as of a fixed single day, namely, May 1, 1953. In Table 8-3, the Home Interview Survey shows the sample's mental health distribution in the period respondents were interviewed. Necessarily, respondents were seen at different times over an eight-month period in 1953–1954. Accordingly, the prevalence yardstick in the Midtown Home Survey is that of the moving or sequential type.

[38] Because of the seeming disability equivalence of the Incapacitated category to hospital patients, it would have been desirable to maintain its separate identity in this discussion and in future analyses. However, the small number of cases affords too slight a base for credible statistical manipulation or inference.

[39] In the interest of readability, hereafter we will as a rule avoid reiterated corrections for sampling error. For the most part, instead, we shall discuss mental health distributions as we find them in the sample, without projecting estimates to the population universe. The reader wishing to make such projections from the total Home Survey sample of 1,660 respondents can add plus or minus 2% to proportions

around 25 or 75% and plus or minus 3% to magnitudes around 50%. These limits are calculated to meet the .05 level of confidence.

[40] This arises from the unlikelihood of achieving 100% detection of mental morbidity cases in a community population.

[41] *Selected* here refers to the fact that obvious physical and mental misfits had already been in largest part screened out. On the other hand, it should not be overlooked that the military environment is at a considerable sociological distance from the family and community settings of these ex-civilians.

[42] This has been fully reported, authors undesignated, in *Chronic Illness in a Large City: The Baltimore Study,* 1957.

[43] "Studies in Medical Sociology: The Relation of Mental Disorders to Population Density," *New Engl. J. Med.,* vol. 23, no. 17, pp. 571–577, Oct. 26, 1944.

[44] *Third Annual Report,* Joint Commission on Mental Illness and Health, 1958, p. 11.

[45] N. J. Cole, C. H. Branch, and O. M. Shaw, "Mental Illness: A Survey Assessment of Community Rates, Attitudes and Adjustments," *A.M.A. Arch. Neurol. Psychiat.,* vol. 77, pp. 393–398, Apr. 17, 1957.

[46] Such cases were classified in one of four categories, namely: (1) psychoses; (2) psychoneuroses; (3) psychophysiologic, autonomic, and visceral disorders; and (4) other mental, psychoneurotic, and personality disorders.

[47] *Chronic Illness in a Large City: The Baltimore Study,* 1957, p. 97.

[48] *Ibid.,* p. 384.

[49] *Ibid.,* p. 391.

[50] The authors report that only psychiatric consultations were sought, and for only 14 (1.7%) of the 809 examined sample subjects (*ibid.,* p. 390). Given that the examiners were internists in the main, this is not exactly a reassuring index of psychiatric interest.

[51] *Ibid.,* p. 96. Throughout the volume, the authors are critically aware of methodological problems in, and lessons to be learned from, the Baltimore investigation.

[52] This estimate assumes that the one-in-three rejection of diagnosed cases by the reviewing psychiatrist, reported for the examined sample as a whole, more or less applies to the subsample of interest here.

[53] *Chronic Illness in a Large City: The Baltimore Study,* 1957, p. 209.

[54] That is, these varyingly underrepresented groups in the studied sample were arithmetically reconstituted to accord with their representation in the population universe. In this process it was apparently assumed that the unknown mental disorder rate of *nonparticipants* from a given demographic segment would approximate the rate known for *participants* from the same segment.

[55] N. Q. Brill and G. W. Beebe, *A Follow-up Study of War Neuroses,* 1955, pp. 322–333.

[56] The region covered was eastern Massachusetts.

[57] R. W. Hyde and L. V. Kingsley, "Studies in Medical Sociology: The Relation of Mental Disorders to Population Density," *New Engl. J. Med.,* vol. 23, no. 17, pp. 571–577, Oct. 26, 1944.

[58] S. A. Stouffer et al., *Measurement and Prediction,* Studies in Social Psychology in World War II, vol. IV, 1950, p. 551.

[59] This probability finds particular reinforcement in the case of the Boston induction station from the fact that it was served by a corps of psychiatrists out of the area's distinguished medical schools.

[60] F. H. Sanford, "The Rising Tide of Mental Health," *Public Health Repts. (U.S.),* vol. 72, no. 7, p. 607, July, 1957.

[61] This double listing was prompted by awareness that to people with limited schooling *psychiatrist* is a more or less unfamiliar term, and *nerve specialist* is its colloquial equivalent. In addition, the interviewer was provided a special code for respondents volunteering the information that they had gone to a psychologist or some other kind of trained psychotherapist, as 13 respondents did.

[62] All but 12 of these reported this fact to the interviewer. The 12 respondents who did not do so were found on our Treatment Census records. Thus, on an extremely sensitive point of personal information, the respondents' 5.4% rate of known under-

reporting is encouragingly small. Moreover, it is probably no larger than the inferred underenumeration of their Midtown patients on the part of an unknown number of therapists collaborating in our Treatment Census operation.

[63] This, of course, is an ambulant patient rate of 24 per 1,000, contrasting with the 8 per 1,000 derived by the Treatment Census. From other evidence, we have gathered that the latter involves an error of unknown size due primarily to under-reporting of cases by some office therapists. The former rate, in turn, is subject to the fluctuations of chance referred to as *sampling error*. Hence the contrast between the two rates may in part be more apparent than statistically real.

[64] This particular finding parallels the results of a 1945 study focused on 623 New York City veterans who had been discharged from military service for neuropsychiatric reasons. Of these, about 82% were judged to be in need of some kind of psychotherapy, but only 5% were getting such care. (See *Psychiatric Needs in Rehabilitation*, study by the New York City Committee on Mental Hygiene of the State Charities Aid Association, 1948.)

[65] This may be compared to the extent of certain specific unmet medical needs revealed by the California Health Survey. The latter disclosed that "a substantial amount of illness does not come to the attention of physicians. For example, about one-fifth of the rheumatism, one-fourth of the deafness and almost one-third of the asthma and hay fever reported in the survey were not medically attended." L. Breslow, "Uses and Limitations of the California Health Survey for Studying the Epidemiology of Chronic Disease," *J. Public Health*, vol. 47, no. 4, p. 171, April, 1957.

In the more recent United States National Health Survey, it is reported that of all persons with one or more chronic somatic conditions fully half (49.7%) were not under medical care. "Limitation of Activity and Mobility Due to Chronic Conditions," United States National Health Survey, *Health Statistics*, ser. B, no. 11, 1959, p. 4.

[66] They answered, for example, "talk it over" with kin or friends, "work it out in the family," "would not know what to say," etc.

[67] *Mental Health Resources in New York City*, New York City Community Mental Health Board, 1957, p. 43.

CHAPTER 9 *Age Groups*

Leo Srole and Thomas Langner

Epidemiological investigations of mental disorder in a general population ultimately arrive at an estimated over-all morbidity rate somewhat as do the laboratory scientists who isolate the first pinhead quantity of a rare element—that is, only after prolonged dredging, sifting, refining, and synthesizing of an enormous mass of raw materials.

The parallel diverges, of course, on this special limitation in the mental morbidity "quantum" estimated for a community population: It is based on a highly selected, i.e., restricted, body of information that has been (1) secured by one specific set of techniques among others possible, and (2) filtered through the particular lens complex of professional criteria and judgments of a few psychiatrists. Such a study, accordingly, must preface the morbidity rate it has laboriously and painstakingly extracted with the plain qualification: "in the independent judgments of these psychiatrists, as applied to this corpus of data, as gathered by these methods. . . ."

To be sure, such a rate offers the study area the only professionally credible estimate available of the over-all magnitude of mental illness, untreated and treated, in its midst—a rare and strategic item of intelligence for a community and its leaders. However, the qualification just stated clamps severe limits on the scientific comparability of the illness rates derived by separate researchers in different communities.

It should be clear that these particular limits do not operate when an epidemiological investigation turns to intergroup comparisons in the "back yard" of its own circumscribed study population. Given due awareness of certain possible pitfalls, such intergroup analyses can be viewed as resting on this common base: Individuals in the various group segments of the study population have been evaluated in terms of mental health status by the *same* psychiatrists, who had weighed the *same* kinds of information, which had been secured by the *same* research methods.

Embodying the demographic variables, these groups offer accessible, more or less standardized, paths through the bewildering maze that is

the social system of every large community. Both epidemiologists and sociologists have traditionally taken these paths in their special searches for clues to pathogenic forces at work in the community.

One problem often overlooked in both fields is the etiological ambiguity inherent in the fact that certain kinds of group affiliations may be individually achieved end results, rather than exogenous antecedents, of an adult's personality and mental health. To circumscribe this ambiguity, we are distinguishing two types of demographic factors, namely, the independent and the reciprocal (see Chapter 2).

Age is an example of the independent type of demographic variable. That is, the individual's position in the community's social hierarchy of age is not self-selected, but is culturally ascribed, more or less on the basis of signal indicators that attest to his stage in the maturation cycle. Indeed, the escalator of age is one of the universal mechanisms to which every society differentially gears some of its indispensable functions, role assignments, and behavioral expectations. The latter can be viewed as a complex of subtle influences and gross pressures that operate from cradle to grave to canalize behavior and guide personality development. Hence, within the individual's life history, phases of the organic cycle and of the social cycle advance more or less in interlocking coordination. Inability of the individual to perform social roles culturally appropriate to his age has been conceptualized in such psychological terms as immaturity, fixation, regression, infantilism, and retardation and is itself usually taken by psychiatry as evidence of malfunction suggesting mental disorder.

Our purpose in this chapter is to view the Midtown population as internally segmented into a series of age-level groups and to test the initial hypothesis that associated with these groups are health composition differences in mental and psychiatric care.

Age, of course, is a continuum type of variable. Therefore, any division of the temporal range must be somewhat arbitrary. The mode of division we have adopted is the standard survey procedure that systematically applies equal spans of time in the predominant form of ten-year age intervals.

TREATMENT CENSUS COUNT

We might pause first to examine what our Treatment Census operation has to report from its one-day prevalence enumeration of patients in hospitals five years or less or in out-patient clinics[1]—duration unlimited.

If we first scan column D in Table 9-1, we observe that the older the group, the smaller, progressively, is the frequency of its clinic outpatients. To judge from this trend, psychiatric clinics predominantly serve Midtown's children and younger adults (i.e., under age 40).

For in-patients (column C), the opposite age trend is apparent in the

Table 9-1. *Treatment Census* (Age Inclusive), Prevalence Rates (per 100,000 Population) of Midtown Patients in Hospitals and Clinics by Age Level

Age level	A. Public hospitals	B. Private hospitals	C. Total in-patients	D. Clinic out-patients
5–19	153	5	158	400
20–29	404	81	485	280
30–39	499	51	550	271
40–49	449	26	475	126
50–59	486	43	529	46
60–69	622	42	664	14
70 plus	1,318	129	1,447	0

sharp contrast between the extremes of the range. Though heavily represented in the clinics, there are few children in the hospitals. Above age 60, on the other hand, the psychoses of senility and other disorders diagnosed as "organic" push hospital rates to their peak. However, among the four "prime-of-life" age groups between 20 and 59, the total in-patient prevalence rates essentially define a "flat" trend.[2]

Our main interest in these particular data attaches to the very different age patterning of patients revealed as seeking and receiving admission to psychiatric clinics and to mental hospitals. Beyond such interest, left as legacy by earlier hospital studies, is this implicit assumption: Although patients represent only a portion of the unknown quantity of over-all mental morbidity, they can be pressed to serve as a visible indicator reflecting differences in the latter as composite of the treated and untreated sick.

In shifting attention to the Home Interview Survey and its sample of age 20 to 59 residents, we will have the means to explore this assumption, at least as it relates to the age 20 to 59 patients reviewed in Table 9-1.

HOME SURVEY SAMPLE: MENTAL HEALTH DISTRIBUTIONS

In the Midtown Home Survey sample of 1,660 adults, our initial task is to inspect its four constituent age groups in terms of their distributions on the psychiatrists' gradient classification of symptom formation (for characteristics differentiating the Home Survey from the Treatment Census, see p. 133). To this end, Table 9-2 is now presented.[3]

In Table 9-2, we might first note the facts that (1) in the youngest group, most recently emerged from adolescence, about 60% fall in the Mild or Moderate categories and (2) the proportions held by these categories remain remarkably stable across the succeeding three age columns.

Table 9-2. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Age Groups

Mental health categories	Age groups			
	A. 20–29	B. 30–39	C. 40–49	D. 50–59
Well	23.6%	16.8%	19.3%	15.0%
Mild symptom formation	37.5	37.6	37.0	33.1
Moderate symptom formation	23.6	22.4	20.5	21.1
Impaired	15.3	23.2	23.2	30.8
Marked symptom formation	9.6	14.7	11.6	16.4
Severe symptom formation	4.1	7.5	7.7	10.5
Incapacitated	1.6	1.0	3.9	3.9
N = 100%	(365)	(388)	(467)	(440)

We next observe that around the more or less unvarying rates of these pivotal, center-of-gravity grades of symptom formation, the frequencies of the other mental health categories *do* vary with age. Specifically, the three age strata above the 30-year line (B,C,D) have appreciably fewer Wells than does the youngest group (A) in the sample.

Of special interest are the three symptom-formation classes subsumed under the Impaired category that defines our criterion of mental morbidity. All three of these conditions approximately double in their frequencies between the extreme age groups, to produce contrasting over-all morbidity rates of 15.3 and 30.8%, respectively; in the two middle age strata they yield an identical rate in the value of 23.2%.

We earlier directed particular attention to the Incapacitated respondents, whom Rennie viewed as ambulant counterparts of hospitalized patients encountered in his experience. They lend themselves, therefore, to comparison with the like-age Treatment Census in-patients reported in Table 9-1. We there observed a substantially flat trend in hospital patient rates of about 5 per 1,000 for all four age strata in the 20 to 59 range.

On the other hand, in the community sample presented in Table 9-2, we estimate that below the age 40 line the incapacitation rate is approximately 13 per 1,000, and above that line it is 39 per 1,000. Clearly, prevalence rates of in-patients cannot serve as approximate indicators of intergroup differences in frequency of presumptively hospitalizable adults living in the community.

To be sure, the incapacitation rates, representing percentages small in magnitude, are particularly susceptible to chance fluctuations due to sampling. In a strict statistical sense, the latter could occasionally wipe out the difference in incapacitation rates between age groups B and C, for example. Such fluctuations are reduced, however, if the groups are enlarged by merging the two youngest age levels (A,B) and by pitting

them against the combination of two oldest ones (C,D). Their difference is further enhanced when due account is taken of the evidence suggesting that people with disorders warranting hospitalization are exceptionally high mortality risks.[4] The inroads of such differential mortality would of course be reflected least in the younger age levels and most among the older people. Accordingly, it is plausible to assume that the 13:39 ratio of incapacitation, which appears when the sample age span is dichotomized, may be narrower than the real difference before mortality does its erosive work.

Returning to the inclusive impairment category in Table 9-2, we might mention that the difference between its frequencies in age groups A and B is statistically significant, above the .05 level of confidence, as is the difference between groups C and D. Nevertheless, we must now revive a relevant technical issue presented at some length in Chapter 3. In discussing the psychiatrists' process of classifying the mental health condition of each sample respondent, we there indicated that this was done in two stages, designated Rating I and Rating II. For each respondent, the former classification was made without the psychiatrists' knowledge of his sociocultural-demographic alignments, or other information that might contaminate their judgments; Rating II was made with such additional data. Prompting this before-and-after experiment was the embattled rationale that the two ratings permit us analytically to assay, against the sample as a whole, whether information on the indicated demographic factors had detectably operated to bias or distort the Rating II mental health classifications. We have already reported that such analysis for the sociocultural type of factors has consistently given a negative reply to that question.

This test for possible judgmental bias on the part of the psychiatrists, attaching to their knowledge of respondent's *bisocial* alignments, cannot be made. It is barred by the fact that respondent's age, sex, and marital status were known to the Study psychiatrist in formulating his Rating I classification. Left open, thereby, is the critical question whether the observed age trend in the impairment rate is more or less unreal—an artifact of the Study psychiatrists' preconceptions—and, even if real, whether it is an idiosyncratic departure peculiar to the Midtown population. There are several types of collateral evidence that can be brought to bear in considering these pertinent questions.

In the first place, we have observations from three different studies of the screened but comprehensive national population of military-age service men (in the enlisted grades) during wartime. These investigations applied different criteria: (1) hospitalization rates for psychoneurosis among precombat men,[5] (2) psychiatric breakdown rates in combat units,[6] and (3) over-all psychiatric discharge rates from the service.[7]

Despite the fact that the upper age limit in the enlisted ranks of the

military population was approximately 37, all three studies are consistent in reporting more psychiatric cases among the older men than among the younger. These findings parallel the difference in morbidity rates between the Midtown age groups A (20 to 29) and B (30 to 39) seen in Table 9-2.

Second, we have already called attention to shorter life expectancies known among people with mental disorders which may require hospitalization.[8] Predicating a similar tendency, perhaps not so frequent, among the greater number of people with less extreme mental disturbances, we would expect an effect on the Midtown age groups' mental morbidity rates in the following directions: To a greater extent than in younger groups A and B, the rates of older groups C and D are smaller than they would have been without the differential intervention of mortality.

On these grounds we can judge that the Midtown age trend observed in Table 9-2 is probably typical rather than idiosyncratic, substantive rather than artifactual; and, if anything, it may be less pronounced than it could expectedly have been had differential mortality not intruded.

HYPOTHESIZED SOCIAL PROCESSES IN THE AGE TREND OF MENTAL MORBIDITY

On this note, we can now move from the *how* to the *why* of the association between age and mental health as documented in Table 9-2. An obvious difficulty besetting such discussion is that age is not a pure factor, but rather a dimension along which many variables operate simultaneously and serially. Processes of premature organic degeneration may intrude in this prime-of-life sample of adults, as may loss of psychological flexibility and adaptability. Furthermore, in Midtown, as elsewhere, age differences are entangled with several other demographic variables, such as socioeconomic status, generation-in-U.S., and rural-urban background. For reasons of neatness in reporting, analytic unraveling of age from these demographic concomitants is better left to succeeding chapters. However, we can indicate here that the basic lines of the age-and-morbidity bond emerge intact from these analyses. Accordingly, under the investigator's prerogative to relate research data to provisional, hypothetical explanations suggested by his own frame of scientific reference, we will consider certain possible social mechanisms that may contribute in part toward effecting the above-mentioned bond. Of course, such formulations in no way rule out the possibility that other kinds of processes may likewise make their own contributions.

First to be emphasized is that the observed age trend in mental morbidity derives from four groups of people who were studied at the same point of time. However, to permit an excursion in speculation around the available data, let us make this simplifying but plausible

assumption about the sample's youngest group (20 to 29): If it were henceforth restudied at ten-year intervals, its current mental health composition would progressively change in the direction indicated by the successive age groups now constituting the Midtown sample. Stated differently, the relationship between age and mental morbidity revealed in Table 9-2 would be essentially confirmed if it were humanly possible to study a single age-group "cohort" longitudinally over a forty-year period.

In this "as if" perspective, the age differentials in Table 9-2 can be visualized as the reflection of *individual* changes in mental health. In net effect, after consideration of those persons who do not change between early adulthood and late middle age, or who improve between those two points, the residual, perhaps predominant, age changes in individuals could be postulated as follows: (1) from original wellness to the subclinical, Mild-Moderate conditions of symptom formation, or (2) from the latter to one of the lesser Impaired classes, or, in turn, (3) from these latter states to the most severe forms of impairment. Through these inferred changes in time, the Well frequency would contract, the Impaired rate expand, and the Mild-Moderate proportion remain roughly the same. Projected, nevertheless, would be a process of individual deterioration in mental health considerable in its magnitude within the study population. Without reifying this projection, let us explore it further under the theoretician's license to proceed on the formula: If Q should be real, then X (or Y or Z) could be one of its preconditions.

One's conceptual stance would undoubtedly determine which unknown (X or Y or Z) to stress in so hypothesizing. One view would of course relate the apparent mental health deterioration to the organic retrogression that seems to accompany adult aging. That the annual frequency of chronic somatic disorder on the national scene reportedly increases from 9.4% of the age 20 to 24 population to 31.1% of the age 55 to 64 population[9] appears at first glance to support this position.

Notable, however, is the fact that many of these disorders are of the type considered to be psychogenic "body language," expressing reactions to stressors in the life situation—and this body language in many cases may include the organic ravages of senility. Thus, if mental and physical health tend to wane together with progressive aging, both may be common and interdependent consequences of a third set of potent forces, namely, the individual's incessant encounters with a particularly abrasive social environment.

On the whole it seems rather doubtful that inherent processes of organic failure could be largely responsible for the impairment rate jump seen between the young Midtown age groups A and B. Nor need biological predetermination be held wholly accountable for the similar jump seen between groups C and D—any more, perhaps, than could the ab-

breviated longevity expectations of a century ago be explained by biological inevitability.[10]

We must leave the precise organic determinants in the age trend of mental morbidity rates to be delineated by investigators in the appropriate disciplines. Within the limiting boundaries of the Study's observational framework, we would call attention to several possible sociocultural disruptions in the transactions between the individual as an integral self and the interpersonal environment as his encompassing universe.

During the normal progression through married life, major pivotal points are first the arrival of children and then their departure from the home several decades later. A general pattern in our social system is its tendency to be casual and haphazard, if not neglectful, in preparing the individual to assume some of his most complicated social roles. Perhaps nowhere is this tendency more pronounced than at the juncture where, in many cases, the adolescent's grab-bag collection of "gutter" values and hearsay about coitus is applied for the first time in sexual intimacy with the opposite sex, and later, when he becomes a parent—as a rule without realistic forearming for the psychological intricacies and hazards of the role. It is as if he wanders onto a stage with other amateur actors and is there compelled to play a leading character part in a family drama —with little or no disciplining or direct experience in that kind of role. This may be likened to learning to swim by propulsion from a solid platform into deep water. Such a predicament in the sociocultural realm has been designated *role discontinuity* and is contrasted with *role continuity.*[11] The latter is probably seen in its most complete form in the prolonged, intensive training for the professional ministering occupations, e.g., registered nurse, teacher, physician, and pastor.

Learning principally by common sense, trial and error, and the remembered example of their own parents, adults of more or less mature personality fit into the new role of parent without apparent excess of strain. On the other hand, among the immature left unprepared for the dynamic impact of their own young children, parenthood may dramatically stir up quiescent, unresolved conflicts or breach defenses that had previously contained them. Such a developmental sequence seems to be involved in postpartum disturbances among women. If so, it would appear to be a credible hypothesis that this particular manifestation is only the visible edge of a less acute but more widespread *crisis of role imbalance,* as we designate it, among relatively new fathers and mothers. Relevant to this hypothesis is the impression of Coleman and Zwerling that the maternal postpartum reaction "is more common in the community than is generally recognized." [12] Also pertinent is the report of Hornick[13] presenting clinical observations of the same kind of reaction in fathers.

Several other clues suggest support for the above hypothesis. One is the senior author's observations among adult mental patients generally that the recent critical turn of their condition is often tied up chronologically and dynamically with the emergence of unacceptable impulses toward their young children. This is paralleled by the generalization of psychiatrist Rittwagen: "Certain it is . . . that emotionally limited and infantile parents find understanding control of their children impossible. With few healthy defenses, they often crumble completely under the pressures of parenthood." [14] Also relevant, perhaps, is a study of 46 young couples who were "average or above in personality adjustment." Referring to their reaction when their first child was born, 38 couples (83%) reported the event as eliciting a severe or extensive emotional crisis.[15]

The pertinence of the above discussion to the specific focus of the present chapter is this: Midtown's age group A (20 to 29) respondents are predominantly childless,[16] whereas those of age group B (30 to 39) are relatively new parents in the main. The above formulation, in other words, may offer a plausible partial explanation for the significant difference between sample groups A and B in their frequencies both of Impaired and Well respondents. If the number of Impaired cases per 100 Well respondents is calculated, then the resulting "Sick-Well" ratio is 65 in group A and 138 in group B. We shall have occasion to return to these groups in the chapter that follows.

Approaching their fifties parents generally enter a new stage in the social cycle of life. Often the prelude to this phase is the growing independence of the youngest child, now in the rebellion of adolescence. This is followed by the parents' more or less complete retirement from the child-sheltering and guidance function, enforced by the severing action of the offspring themselves. Several consequences may issue in the wake of this event. First, there is the change to an emptied, fundamentally "broken" home and a greatly shrunken range of parental activity. Among its other psychological functions, the parental role is generically akin to an institutional "office," into which is poured a considerable investment of personal identity and sentiment. Both roles carry leadership responsibilities that are ego buttressing and stabilizing, and both leave voids difficult to fill when they are lost.[17] Second, if the marital relationship between the parents has previously been less than mutually equilibrated, the void tends to bring out old and new strains as the couple face their change of family life alone.

Third is the anthropological fact that societies place differential value on the several age levels in the population. If China in its classical period was at one extreme in prizing the old over the new, especially in venerating the family's aged members,[18] contemporary American society is probably close to the opposite pole in tending to equate "old" with "junk." [19] Thus, when retired to the side lines as spectators of their

children's own families, often under the implicit injunction that they should be seen but not heard, parents are aware that they have begun the slide of denigration in the eyes of important others.

Fourth, a century ago aging had psychological support in the continuity of "life eternal" under the religious doctrine of the immortality of one's essential self, or soul. Secularization following upon the scientific and industrial revolutions of the nineteenth century has widely toppled this pillar of religious faith. Thereby, approaching death has come to be viewed not as the curtain rising to the life beyond but as the curtain descending with the absolute closure of "finis."

On all these counts, we would suggest, the 50 to 59 years of life are the opening to a period of jolting discontinuities in rapid sequence. Thus, of an American novelist who writes about "the fretfulness and decline of heart in middle-class people of middle years" it has been said that "his characters are constantly mourning as they cower beneath the assault of age on their ego." Appropriating a term from surgery, this is the beginning of years of "insult" to the individual's integrity and sense of self-worth.

When this drama of accelerating "fall" and role discontinuity is played out in adults harboring potentials for overt mental malfunction, we postulate that the consequences may in part become psychiatrically visible[20] —for example in the depression and involutional states of late middle age. The consequences may also come to medical attention in such diagnostic forms as hypertension, arthritis, arteriosclerosis, senility, and other observed somatic expressions of overwhelming psychic stress in the aging. Perhaps the magnitude of these consequences in first impact can be crudely discerned from the shift of mental morbidity rates between Midtown's age groups C (40 to 49) and D (50 to 59), as reported in Table 9-2. Among the former group, for example, the sick-well ratio is 120, slightly under that of our respondent sample as a whole. Among the latter, significantly, this ratio rises to 205.

We have here proposed a series of hypotheses that attempt to articulate certain sociocultural observations to the age pattern of mental morbidity discerned in the Midtown sample. Further research will be required to tell us to what extent these postulated connections are real.

If these postulates should be more or less sustained, the following summarizing propositions might conceivably be in order:

1. The individual's infancy and childhood are crucial in implanting the predispositions for his subsequent mental health.

2. Among people with susceptibilities in the unfavorable direction, actual precipitations of disabling illness tend to cluster around points of individual shift in major social roles.

3. Where, in addition, the individual's defense-building preparation for one of these new roles is faulty, as not infrequently happens in our society,

the chances are magnified that the culturally impelled shift will carry the force of both a situational crisis and a personal trauma.

4. Some of these role shifts follow from life-changing accidents and disasters that tend to befall people more or less at random in time and place. Others, given the necessary preconditions, tend to occur at more or less regular junctures in the adult social cycle.

5. One emergence of role imbalance among predisposed adults may occur when the arrival of children bestows the mantle of parenthood on shoulders unable to bear it; another may occur several decades later, when the active parental role is terminated and our contemporary values begin to condemn the individual to a castoff role of social obsolescence, deflated personal stature, and accelerating slide toward the final trauma of discontinuity; together, these two kinds of role change can be seen as major precipitating patterns that perhaps are no small links in the tangled chain of pathogenic processes at work in the Midtown population.

6. In numerous cases, the concatenation of a general predisposition to mental illness and a specific vulnerability to these patterns of precipitation may be transmitted behaviorally in a direct family line (i.e., from parent to child to grandchild) in the absence of a transmitted genetic defect.[21] If so, the possibilities of mapping preventive interventions at certain regular points in the individual's social cycle would appear to be considerably enhanced.

HELP-NEED AND THE PATIENT-HISTORY VARIABLE

An earlier section of this chapter presented the Treatment Census report of age-specific rates for Midtown patients in psychiatric hospitals and clinics. From these data we learned that prevalence of hospitalized patients does not vary among the age segments within the 20 to 59 range, whereas the prevalence of clinic out-patients within this chronological span decreases with age level.

When the unit being enumerated is the patient in a therapeutic facility, as was the case in our Treatment Census, then its frequency in a particular age group can only be calculated as a rate per 100,000 of the *total* population in that group. Such a rate, strictly speaking, only answers this query: Among how many people in a given group do two specific events occur in conjunction, namely, (1) perception that mental illness is present and (2) entrance into a psychotherapeutic service for the care of that illness?

In the Home Interview Survey, on the other hand, we can isolate within each age group the Impaired category of respondents, as identified by the Study psychiatrists. Although a relatively small segment of the group's total population, the Impaired respondents are a more relevant

criterion in weighing the selection problems hinging on what kinds of people are getting professional attention and what kinds are not. That is, the impairment class can be considered the population at risk of needing some form of professional help. With Rennie's support on the issue, we find warrant in equating the morbidity criterion of functional impairment with the service criterion of help-need. If this is correct, we can ask how these Impaired respondents distribute themselves among three crude types of "patient histories," namely, (1) current out-patients —both of clinics and office therapists, (2) ex-patients—both of hospital and ambulatory facilities, and (3) never-patients. In Table 9-3, we present these distributions for the Impaired of each age group.

Table 9-3. *Home Survey Sample* (Age 20–59), Impaired Respondents' Distributions on Patient-history Classification by Age Groups

Patient-history	Age groups			
	A. 20–29	B. 30–39	C. 40–49	D. 50–59
Current out-patients (ambulatory)	8.9%	8.9%	5.6%	1.5%
Ex-patients (ambulatory or hospital)	25.0	26.7	18.5	19.3
Ever-patients	33.9	35.6	24.1	20.8
Never-patients	66.1	64.4	75.9	79.2
No. of Impaired = 100%	(56)	(90)	(108)	(135)

Before discussing the above data, several preliminary observations might be offered. First, a review of Table 9-2 will reveal that the Impaired respondents in the two oldest age brackets (C,D) had a relatively heavier concentration of incapacitated-grade people than did their Impaired equivalents in the youngest age groups (A,B). From this fact, we can infer that the older Impaired respondents on the whole had more urgent help-need cases than did their junior counterparts. Second, among chronic disorders generally, the chances of exposure to appropriate professionals (in this context, to psychotherapists) would in theory tend to mount cumulatively with increasing age.

If, therefore, we were plausibly to expect that the number of help-needy who had been in therapeutic facilities would expand progressively in successive age groups, Table 9-3 does not confirm the expectation. In fact, it reveals the contrary to be the case—i.e., the older (groups C,D) Impaired have the larger proportions of never-patients. In succeeding chapters we shall see other instances of differential flow of the help-needy population through the clogged channels of the therapeutic services.

SUMMARY

The sample of Midtown adults examined by our Home Survey operation was here viewed as divided into ten-year intervals on the spectrum of age.

In the distributions of the sample's four age groups on the symptom-formation classification scheme applied by the Study psychiatrists, the following main patterned tendencies were seen:

1. The Mild-Moderate categories of symptom-formation, presumably defining the subclinical range of mental disturbance, were almost identically represented in all the age brackets.
2. The Well proportions in the three older groups (i.e., above the 30-year age line) were significantly smaller than that of the youngest adults, age 20 to 29.
3. Standing as Rennie's criterion of mental morbidity, the Impaired condition described a three-step progression in frequency along the sample's age continuum. It was least prevalent among the youngest respondents, most prevalent among the oldest, and identically intermediate in frequency among the two middle age groups.

The possibilities were considered that this age trend in mental morbidity rates was a reflection either of an atypical population or of an artifact in the classification process of the Study psychiatrists. Available evidence suggested the remoteness of such possibilities.

The sample's four age groups were studied at a single point of time, and such a cross-sectional survey is very different, operationally, from a longitudinal study of a single age cohort over a four-decade span of time. Nevertheless, it seemed to be a plausible assumption that if the latter investigation could be conducted, the basic lines of the relationship between age and over-all mental morbidity would be reproduced more or less as found in Midtown and in other general populations cited.

This reasonable assumption permitted us to draw a potentially important suggestion from the Midtown age trend in frequency of mental impairment; namely, a substantial process of slippage in mental health seems to mark the path of individual progression through the 20 to 59 age range.

On the chance that this inference would ultimately be sustained, it was necessary to propose hypotheses which might explain, at least in part, how such decline in mental health could come about through the prime-of-life segment of the adult years.

It was possible, of course, to hypothesize that such deterioration is first generated by the inherent trend toward organic wear and tear and toward loss of psychological flexibility that seems to accompany the approach to journey's end. With specifying elaboration of this general

hypothesis being left to more appropriate disciplines, it was held here that such somatic change could hardly, in itself, be independent of the individual's weathering exposure to the particular elements of his social environment and its potential abundance of stressors.

If there is etiological "elbow room" for the influence of sociocultural factors upon mental health along the temporal course of adult aging, there was warrant to suggest hypotheses specifying the identity of several such potential factors.

The series of postulates advanced to this end did not represent an effort to include all promising sociocultural elements that might be involved. Instead, we confined ourselves to major facets of the rather powerful umbrella concept of *role discontinuity*. This refers to a variety of situations of disjunction or jolting transition in shifting from one social role to another. Many individuals in our society experience such rough stretches in the cycle of social roles. However, when this happens to human vehicles built from childhood with tendencies toward psychic malfunction, then these rough stretches may be points at which latent pathology tends to break out into overt disability.

In line with this theory, offered to account for the marked difference in mental health composition observed between the 20 to 29 and 30 to 39 age groups was the recent shift of the latter to the parent role—often with few specific defenses for the new psychological complexities that a young child presents to the disturbed adult.

Offered to account for a similar difference between the 40 to 49 and 50 to 59 age groups was the recent termination of the latter's active child-rearing functions, often without adequate prior preparation for the role vacuum thereby created. We further postulated that aggravating this development for such people in late middle life was the beginning of a process of social downgrading that is particularly sharp in American society. This, in recent years, has given the over 60 age segment in the population many of the stigmata of a minority group subject to social discrimination on a purely biological criterion. Also hypothesized as an aggravating factor is that the continuity between life and afterlife, historically a rock of religious doctrine and of individual support in the declining years, has largely been worn away by the tides of secularization.

All in all, compared with the situation a century ago when grandparents (1) were more completely integrated in a stronger kinship group, (2) were more highly valued by children and community alike, and (3) were sustained by expectations of the life beyond, the sixth decade of life (i.e., age 50 to 59) now carries a quite different atmosphere and meaning for its occupants. Despite greatly increased longevity and higher material standards of living, this phase of life now has a built-in series of stressors

that appear to be noxious for many people and functionally disabling for the predisposed in particular.

Thus, the age trend in mental health composition, as exposed by the Midtown sample, seems to be compatible with the evolution of the adult's parental role and the notion of role discontinuity as a precipitant of mental morbidity.

Also of concern in this chapter was the age representation in the traffic of Midtowners through available psychiatric facilities. From its coverage of all patients in mental hospitals and clinics, our Treatment Census could give us rates expressing the coincidence of need perceived and therapy sought, relative to the total population in each age segment. For the four age groups in the 20 to 59 range, at least, these rates described a level age trend for hospital patients and a descending age trend for clinic patients.

In our Home Survey, on the other hand, the Impaired respondents represented the help-needy who are at risk of requiring psychiatric help. Calculating current out-patient rates (in clinic and office facilities) and ex-patient rates (in hospital and ambulatory services) revealed the under age 40 Impaired as having higher frequencies of both than their older equivalents in symptom-formation.

The double-barreled inference to be extracted is that with less pathological provocation on the whole, younger adults in need are more likely than their senior counterparts to find their way to a psychotherapeutic haven. Certainly, on the scale of age psychiatric patients are hardly representative of the population presumably in need of professional help.

FOOTNOTES

[1] From office therapists it was not feasible to secure information on age of patient or any other demographic factor except one to be discussed in Chap. 13.

[2] To check this age trend in prevalence, we have also determined the age-specific, one-year incidence rates of Midtown residents admitted to a public or private mental hospital from May 2, 1953 through May 1, 1954. Since the prevalence count included patients hospitalized for the first time and also those who were repeaters, we similarly included in the annual incidence count both first admission and readmission cases. The general nature of the age trend that emerged is indicated by hospital incidence rates in the 20 to 29 and 50 to 59 age groups of 333 and 360 (per 100,000 corresponding population), respectively.

[3] In presenting distribution tables to follow we will not systematically introduce a statistical measure that many students might consider mandatory, i.e., significance of difference between two percentages. On the whole we are primarily concerned not with the specific size of the difference (e.g., in morbidity rates) between pairs of groups, but with the general pattern and direction of the distributions across the entire spectrum of our test variables. Moreover, accreditation of statistical significance may prove to be seriously misleading if the relationship so certified in a table melts away when an additional factor is analytically introduced. On both these grounds we intend to put such seeming statistical imprimaturs to sparing use.

In the text, hereafter, a difference between two percentages will not be tagged as significant unless it is at or above the .05 level of confidence. This criterion means that the odds are at least 95 to 5 against the difference being a chance occurrence due to fluctuations inherent in sampling.

[4] M. Kramer, "The Concepts of Incidence and Prevalence as Related to Epidemiological Studies of Mental Disorders," *Am. J. Public Health,* vol. 47, no. 7, p. 838, July, 1957.

[5] S. Stouffer et al., *The American Soldier,* 1949, vol. I, p. 114; vol. IV, p. 512.

[6] Col. A. J. Glass, "Observations upon the Epidemiology of Mental Illness in Troops during Warfare," in *Symposium on Preventive and Social Psychiatry,* Walter Reed Army Research Institute, 1958, p. 194.

[7] E. Ginsberg, *The Lost Divisions,* 1959, p. 111.

[8] For a wider range of cases see also the study reported in "Prognosis after Recovery from Disability Due to Mental Disorders," *Statistical Bulletin,* vol. 38, Metropolitan Life Insurance Company, January, 1957.

[9] S. D. Collins, K. S. Trantham, and J. L. Lehmann, *Sickness Experience in Selected Areas of the U.S.,* Public Health Monograph, 1955, pp. 8–21. This monograph reports data on 100 diagnoses, classified by severity, from 5 large surveys that covered 3 communities and 36 state populations. Involved were "80,768 full-time person-years of observation."

[10] For discussion of the problem in large perspectives, see Gardner Murphy, "Biological Changes in Man," *Human Potentialities,* 1958, pp. 218–242.

[11] For these concepts we are beholden to an unusual series of papers contributed by social scientists and psychiatrists. Cf. R. Benedict, "Continuities and Discontinuities in Cultural Conditioning," *Psychiatry,* vol. 1, no. 2, pp. 161–167, 1938; T. Parsons, "Age and Sex in the Social Structure of the United States," *Am. Sociological Rev.,* vol. no. 5, pp. 604–616, October, 1942; L. Cottrell, Jr., "Age and Sex Roles," *Am. Sociological Rev.,* vol. 7, no. 5, pp. 617–620, October, 1942; I. Belknap and H. J. Friedsam, "Age and Sex Categories as Sociological Variables in the Mental Disorders of Later Maturity," *Am. Sociological Rev.,* vol. 14, no. 3, pp. 367–376, June, 1949; M. E. Linden and D. Courtney, "The Human Life Cycle and Its Interruptions: A Psychologic Hypothesis," *Am. J. Psychiat.,* vol. 109, no. 12, pp. 906–915, June, 1953; and M. Mead, "Cultural Discontinuities and Personality Transformation," *J. Social Issues,* Supplement Series, no. 8, 1954.

Particularly important are the investigations of T. S. Tyhurst, as summarized and advanced in his paper, "The Role of Transition States—Including Disasters—in Mental Illness," *Symposium on Preventive and Social Psychiatry,* Walter Reed Army Institute of Research, 1958, pp. 149–172.

[12] M. D. Coleman and I. Zwerling, "The Psychiatric Emergency Clinic," *Am. J. Psychiat.,* vol. 115, no. 11, pp. 980–984, May, 1959.

[13] E. Hornick, "The Post-partum Depression among Men," unpublished paper.

[14] M. Rittwagen, *Sins of Their Fathers,* 1958, p. 222.

[15] E. E. LeMasters, "Parenthood as Crisis," *Marriage and Family Living,* vol. 19, pp. 352–355, November, 1957. It is of interest that inadequate preparation for the parental role was the explanation offered by most of the subjects who experienced the crisis. One mother was quoted to the effect that "we knew where babies came from, but we didn't know what they were like."

[16] Of this group, almost half (48%) are still single, whereas in the next older group the corresponding figure is 27%.

[17] It is of course no accident that in many cultures the marriage ceremony and celebration symbolically acknowledge the underlying grief of the parents of bride and groom at losing not the child but the sentiment-charged child-rearing office.

[18] M. Granet, *Chinese Civilization,* 1930, pp. 327–343.

[19] Explicitly applied first to the consumer products of industrialization, this value equation has implicitly come to be applied to human beings as well. The evidence for this historical transformation of a key cultural value will be presented elsewhere: L. Srole, "The Industrial Revolution and the Concept of Individual Obsolescence," paper in progress.

[20] In discussing the psychotic mother of a delinquent, Rittwagen observes that such parents "usually become overwhelmed and threatened when their children start to assert themselves and grow away from them . . . because of their need for their children's love and their own immature dependency." *Op. cit.*, p. 135.

[21] A mentally disturbed parent, locked into a morbid relationship with the child who has innocently exacerbated his pathology, will likely implant that child with a double dosage of vulnerability to his own subsequent offspring. As in congenital syphilis, each sick parent is potentially an infecting agent, through his behavior, of subsequent generations of descendants.

CHAPTER 10 *Sex and Marital Status Groups*

Leo Srole and Thomas Langner

Vive la difference! is a universal salute to the complementary biological arrangements of the two sexes. Building on these basic biological designs, cultures universally have fashioned variously differentiated and complementary social roles for males and females as they proceed together through each successive stage of the life cycle.[1] These parallel role "tracks" are so firmly mapped from early childhood onward that sex-appropriate behavior becomes a major theme in the unfolding image of one's identity, with lasting impress on personality development. Thus, organic and social forces interweave to make sex one of the primary lines of differentiation in a community population.

Clearly the question of the linkage between the sex variable and tendency toward mental illness is of fundamental interest and has long attracted epidemiological investigators. In general, studies of hospital patients have shown higher rates for males. On the other hand, surveys of community populations have not produced consistent results. Some, like the recent Baltimore chronic illness study, report higher mental disorder rates among females,[2] whereas others yield similar rates for the two sexes.[3]

TREATMENT CENSUS FINDINGS

The Midtown Treatment Census, covering the entire age range, does not offer particular clarification on the point. Among its clinic patients, mainly adolescents and younger adults, males outnumber females in prevalence rates at almost all age levels from 5 upward. For Midtown hospital patients confined less than five years the situation is more complex. Specifically, males have higher rates in all age groups between 5 and 29, females are more numerous in the decade age levels above the age of 40, and the two sexes are evenly balanced in the 30 to 39 age group.

HOME SURVEY SAMPLE: MENTAL HEALTH DISTRIBUTIONS

For a more promising test of the hypothesis that differences in mental health composition exist between the two sexes, we can refer to the Midtown Home Survey and its representative sample of the entire Midtown population in the 20 to 59 age range. There we can compare the mental health distributions of males and females within each of the four decade age groups. Such comparison reveals that in no age group is there a statistically significant sex difference. Stated differently, the separate mental health distributions of males and females are essentially that of their age group as presented in Table 9-2. Thus, we can seemingly infer that in the defined Midtown adult population, at least, the sex factor is unrelated to the frequency of mental morbidity.[4]

It will be remembered, however, that the Study psychiatrists knew the sex of each respondent in formulating their preliminary Rating I classification. Accordingly, we are unable to assert with complete confidence that the null relationship just reported does not reflect different preconceptions held by the psychiatrists about the sexes. Of course, such prejudgments could convert a true difference into a spurious no difference. We shall deal with this problem in connection with the variable of marital status, which we can now proceed to explore.

When Midtown males and females are next analyzed in relation to the biosocial factor of groups varying in marital status, a somewhat sharper picture emerges. It should be emphasized, however, that, unlike age and sex, marital status in our view cannot qualify as an independent demographic variable relative to mental health. On the contrary, elements of mental health may be crucially involved in determining whether or not individuals choose to marry; if they do so choose, whether or not they are successful in finding a spouse; and if they are successful in this respect, whether or not the marriage is subsequently broken by divorce.[5]

Thus, far from being independent of mental health, marital status must be regarded as a factor that is very largely open to determination by personality processes. However, it is also obvious that the several variants of marital status, once established, may exert different kinds of change impacts upon subsequent mental health. If so, marital status and mental health are related to each other by a process of mutual interaction in time. On this criterion, marital status, for purposes of the present Study, must be placed in the category of reciprocal [6] demographic variables.

In order to isolate the specific change potential of each kind of marital condition, a different kind of research undertaking is required. That is, it would have to be the before-and-after type of investigation which starts with samples of individuals who are psychiatrically well delineated at the threshold of the marrying age, and are later restudied psychiatrically in terms of their intervening marital paths and experiences. The

present Study, focused on a sample of individuals at one point in time, cannot empirically disentangle the specific consequences of each marital state for subsequent changes in mental health. Nevertheless, it can attempt to weigh the findings from its marital groups in terms of such concepts and knowledge as can be relevantly marshaled. One useful purpose, of course, would be to circumscribe further pockets of high mental morbidity risks in the Midtown population. Another would be to extract germane hypotheses that might be the focus of differently designed investigations in the future. New postulates, thrown off by a researcher as targets for his successors, are an indispensable part of the scientific process.

As we probe each of a series of demographic factors in the Midtown sample population, our first interest is addressed to the varying prevalence of mental morbidity. Up to this point we have learned that such morbidity on the whole tends to increase in frequency with age. Accordingly, in coming now to assess marital status and its links to mental health, the age factor must continue to be kept firmly in the picture, especially as the married group on the average is older than the unmarried and younger than the widowed.[7] Therefore, in comparing the several marital groups we must again do so only for people of like age.[8] Furthermore, there is a possibility not to be ignored that the linkage to mental disturbance of one or more marital conditions may not be the same for men and women.[9] Accordingly, to test this possibility in assessing marital status we must take into account the sex as well as the age factor.

However, when three demographic factors must be analyzed simultaneously against a fourth, i.e., mental health, the number of demographic subgroups produced becomes inordinately large and the number of sample respondents left in such subgroups diminishes correspondingly. As a result, the small number of cases in the extreme categories of the morbidity range thin out to a point of statistical instability. This can be countered only by merging the Incapacitated, Severe, and Marked symptom-formation classes into the more comprehensive Impaired category that is our inclusive criterion of mental morbidity. For economy of tabular presentation, we shall in the present chapter concentrate on this key category alone.

Turning now to Table 10-1, we can there examine the impairment frequencies among sample men and women who are married.[10] Within every age group, it is amply clear, the married men and the wives are nearly identical [11] in their proportions of individuals who fall into the Impaired range of the mental health classification. It must be added that these men and women are also alike on all age levels in their frequencies of individuals classified as Moderate or Mild symptom formation, or as Well.

Table 10-1. *Home Survey Sample* (Age 20–59), Proportion of Impaired Respondents among Married Males and Married Females of Like Age

	Age groups			
	A. 20–29	B. 30–39	C. 40–49	D. 50–59
Married males.....	11.7%	19.6%	19.0%	25.7%
N = 100%.....	(60)	(112)	(142)	(136)
Married females.....	13.4%	22.1%	18.1%	30.6%
N = 100%.....	(112)	(136)	(155)	(134)

These close similarities in over-all mental health composition do not necessarily imply like effects on the mental health of the two sexes that are specifically attributable to the married condition. That is, the data may conceal the operation of several different kinds of influence which happen to add up to the same net result. For example, it has been hypothesized that, compared with her spouse, the wife, being more circumscribed in her extrafamily role outlets may be far more dependent on the marital relationship to "achieve a comparable over-all satisfaction-frustration balance. . . . In highly oversimplified terms, the husband may depend on the marriage to gratify a minor portion of his needs while the wife may depend on it to gratify a major portion of hers." [12] If so, the wife would tend to be more vulnerable psychologically than the husband to conflicts generated in their relationship to each other. In that case, and other factors being equal, it could be hypothesized that marital strains are potentially more unbalancing for women than for men, a situation that might conceivably register on the former by swinging their impairment rates higher and their Well proportions lower than before marriage.

Of course, other factors are not equal. Obviously, on his part a husband is centrally involved in a career-work situation. He may depend on this as a major source of gratification, but in turn it can generate its own inherent set of pressures. In the position of family breadwinner, his dependence upon the work role would probably tend to make him particularly vulnerable to its manifold points of potential stress. If so, such stresses would plausibly tend to have greater impact on the husband than on his wife.

If, as is hypothesized, conflicts in the marital relationships are more serious for wives and strains in the work setting more disturbing for husbands, then the similarities in the mental health distributions of the two groups would seem to suggest that the net effects of the two different sets of potentially unbalancing forces may be of approximately the same

magnitude. Accordingly, our data notwithstanding, we cannot assume as yet that the married state has like mental health consequences for the two sex groups in the Midtown population.

We move now to inspect the single[13] men and women (Table 10-2), with their impairment rates on each age level. The rates for wives have been transposed from Table 10-1 to serve as an additional comparison group.

Table 10-2. *Home Survey Sample* (Age 20–59), Proportion of Impaired Respondents among Single Males, Single Females, and Wives of Like Age

	Age groups			
	A. 20–29	B. 30–39	C. 40–49	D. 50–59
Single men.....	20.5%	30.4%	37.5%	46.1%
N = 100%.....	(78)	(46)	(32)	(26)
Single women.....	11.2%	12.1%	24.6%	25.6%
N = 100%.....	(98)	(58)	(57)	(43)
Married women.....	13.4%	22.1%	18.1%	30.6%
N = 100%.....	(112)	(136)	(155)	(134)

We observe first that on none of the four age levels do the single females differ significantly in impairment rates from the wives.[14]

The single men, on the other hand, reveal a strikingly different story. Relative to the morbidity rates for the single females—and to the married men in Table 10-1—the impairment frequencies of the bachelors are higher by wide margins[15] along the entire axis of age. More precisely, on three age levels the impairment rate of the bachelors is consistently about twice or more that of the single women, and on one age level (40 to 49) this rate is half again larger than that of the spinsters. What can account for this large contrast across the entire age range covered? Three major directions of interpretation seem open to us in attempting to answer the question posed about the observed differences between unmarried men and women: (1) The differences are an artifact of the Study psychiatrists' preconceptions; (2) the unmarried state is more pathogenic for males than for females; (3) there is a differentially selective sifting of single males and females into the Study area.

The first possible interpretation is opened by the fact that in making the Rating I mental health assignment for each respondent, the Study psychiatrists knew his marital status (and also sex and age). Accordingly, we cannot test for the possibility that this key piece of information had inadvertently served to bring certain preconceptions into the psychiatrists' evaluations of respondents' mental health. Such a preconception might

readily be derived from previous studies of patient populations that uniformly have shown exceptionally high rates of hospitalization for unmarried adults. This could then be projected upon a community population through the psychiatrists' assumption that nonmarriage is a potential confirming sign of personality malfunction and psychopathology.

If this assumption did enter into the psychiatrists' classification process, Table 10-2 seems to tell us that it was applied to the single males but not to the single females. If so, this would appear to imply a sex bias directed only toward bachelors.

However, if such a bias were operating, the psychiatrists would be most unlikely to view the unmarried condition among metropolitan males in the age 20 to 29 range as in any way a pathognomonic sign. Yet Table 10-2 reveals the impairment rate among these youngest single men to be almost twice that of like-age single females. It may then be argued that the bias was directed only to bachelors above the age of 30. If so, the impairment rates of the latter would have deviated from those of like-age spinsters to a greater extent than the difference between single males and single females in the youngest group. However, Table 10-2 shows that beyond the age of 30 the bachelor-spinster differences in impairment rates are on the whole of about the same magnitude as the difference below the age of 30. Hence the possibility of judgmental bias narrowly attached to older unmarried men finds no apparent support in the available data.[16]

By extension, parenthetically, it also appears unlikely that the Study psychiatrists were laboring under a generalized sex bias that, with knowledge of sexual identity of respondents, could have contaminated their judgments of mental health. This improbability finds a limited measure of reinforcement in a community sample study conducted by Bellin and Hardt among 1,541 people in the age range over 64.[17] Their methods in many respects paralleled those of the Midtown Home Interview Survey. Their criterion of mental morbidity was symptom formation suggestive that a respondent "may be certifiable" for admission to a state mental hospital. Certainly this is a far more exclusive criterion than that applied to the Midtown sample. Nevertheless, it is of some interest that the Bellin and Hardt study parallels the Midtown finding of no over-all sex difference in morbidity rates. All in all, therefore, it seems rather unlikely that this Midtown finding conceals any distorting bias in the psychiatrists' mental health evaluations of the two sexes.

With reference again to Table 10-2, a second interpretation of the data would fix on the possibility that singleness for males is somehow more pathogenic than is spinsterhood among females. Although lacking face plausibility, this is an issue to which we shall return presently. Indirect assessment of such a possibility may follow from the third, and very different, line of interpretation. This focuses on a complicated process of

psychosocial selection intrinsic to mating phenomena in Western societies —one that tends to sort somewhat different kinds of individuals into the several marital groups.

We have earlier suggested that personality elements are inevitably involved in determining marital status. How, in general, do they seem to operate in relation to the unmarried? Selection criteria permit the definition of several different types of single people. One is the self-chosen, or *confirmed*, type often found beyond the age of 30, and characterized on the whole by personalities that require the individuals, for one of a series of possible psychodynamic reasons, to avoid seeking or accepting a spouse. It can be hypothesized that this type tends to fall outside the Well sector of the mental health spectrum.

However, not all single people are of the self-chosen type. Beyond these, a key factor in the selection process hinges upon cultural forces that press upon males the active initiator role in courtship and upon females the passive secondary role. Under these culture-bound roles, males who actively seek a wife but fail to find acceptance of their overtures or proposals can be represented as the *rejected* type. It seems likely that repeated rejections of an eligible man, in the open, eager-beaver market of single women, can only result from the handicap of physical or personality deviations,[18] often accompanied by intrinsic mental disturbance. On the other hand, limited by their circumscribed and passive role in the market of eligible men, women awaiting but failing to get an acceptable proposal of marriage often are not so much rejected as *unchosen*.[19]

Now, in a community that has like numbers of single males and females, the number of bachelors, self-chosen and rejected, will force a similar number of women into spinsterhood. Some few of the latter will be of the self-chosen type, probably corresponding in mental health composition to the parallel type among the bachelors. Similarly, among the unchosen women will be many bypassed because of physical or personality deviations that would likely make them the equivalent in mental health make-up of the rejected bachelors.

Here, we hypothesize, another cultural factor enters, namely, that many males in their active courting roles tend to choose a wife who enhances their culturally conditioned self-image of masculine dominance. As a result, we suggest that women with strong, independent personalities, or with other especially gifted native endowments,[20] are bypassed more often than their sisters with less outstanding qualities. Thus, in a community with like numbers of males and females we postulate that, compared to the rejected bachelors, the unchosen spinsters, including such "special" women, will as a group be more heterogeneous in mental health composition.[21]

In a community like Midtown, or Manhattan at large, the selection processes sorting people into the several marital categories become vastly

more complicated. As reported in Chapter 5, here among the unmarried there is a considerable excess of females, reflecting that more young women than young men migrate to Manhattan, principally from areas beyond New York City. Because the barriers to breaking away from family and kinship ties are usually far higher for female migrants, it appears likely that on the whole these women include a larger representation of the hardy in character and mental health than do the male migrants. Among them would probably also be found the outstanding women, whose aspirations for finding an acceptable mate would seem best attainable in the metropolis.

The second phase of personality screening winnows the unmarried in-migrants who settle permanently in Manhattan and those who make the round trip back. At this point, Manhattan's unbalanced sex ratio would tend to have different sorting-out consequences for these newcomer males and females. Specifically, the more disturbed the male, the more likely would Manhattan's excess supply of single women offer him a larger chance than he would have back home of finding acceptance, rather than rejection, as a suitor. On the other hand, the more disturbed the female, the more likely would Manhattan's undersupply of single men diminish her chances of finding a husband there. In the light of the different marriage chances in the home town recently departed, the more disturbed males would tend to stay in Manhattan, whereas the more disturbed females would tend to return to their homes. In other words, this particular selection process would tend to further "purify" the remaining unmarried Manhattan females as a mentally healthier group on the whole, while enlarging representation of the disturbed within the permanently settled bachelor group.

The final stage in the sifting process occurs when the permanently settled single men and women encounter each other in the search for a spouse. The decisive factor here is again the unbalanced sex ratio, as manifested in Midtown's age 20 to 29 unmarried group, where the females outnumber the males by a ratio of 125:100.

To judge from our sample, for every 100 men of age 30 to 39, 70 are married and 30 are bachelors. Hypothetically, if these 70 husbands (in every 100 males) had drawn their wives from the original 125 single women age 20 to 29 just mentioned, then remaining unmarried a decade later would be 55 of the latter women (i.e., 125 minus 70). By estimate from our sample, about one-fourth of these single women may finally have left the study area, and probably the City, for better husband "pickings" elsewhere.

Now let us consider the hypothetical 30 bachelors (per 100 males) and 42 spinsters (55 minus the 13 departures) in the age 30 to 39 group —whose numbers are convertible into a sex ratio of 140 females per 100 males. These bachelors, as the self-chosen or rejected residue

of a group that a decade earlier already had relatively many Impaired individuals and few Well, are now even more heavily unbalanced in number of Impaired relative to number of Wells. That is, in the interim the healthier men had chosen to marry, thereby depleting the representation of Well individuals among the remaining bachelors.

The age 30 to 39 spinsters, on the other hand, are the residue of a group characterized a decade earlier by a relatively high Well rate and a low Impaired rate and presumably further purified since by the probable dominance of disturbed females among those departing the area.

The single women remaining are likely in largest part to be of the unchosen type. But it will be remembered that these are women now well established in careers based in Manhattan's pace-setting economy.[22] And it is postulated that they are unchosen for either of two principal reasons: (1) They have special qualities which, by cultural emphasis in mate selection, leave them unchosen by the kind of men they would accept; (2) they are affected by the sheer quantitative scarcity of eligible men, which reduces their chances of establishing after-work relationships with potential mates—even for women who, under a more favorable sex ratio, would certainly be among the chosen.

This interpretation, cast in the form of hypotheses or probability statements, rests on a formulation of personality selection mechanisms in mating. Fitted into this formulation have been observations about a series of sociocultural factors that independently of each other influence the personality selection processes. The major ones are (1) sex differentials in self-recruitment for in-migration to and emigration from the metropolis, (2) generalized sex-differentiated patterns in courtship and mate choice, and (3) a local sex ratio characterized by an excess of females.

It is probable that each of these by itself tends to have the opposite effects of *enlarging* somewhat the number of non-Well males and *reducing* somewhat the number of non-Well females who remain in the single state. Operating together in Midtown, the combined effect of these factors, we postulate, is to leave behind in the unmarried category, on all age levels, males and females who are highly contrasting in their group mental health composition.

Remaining open is the earlier question suggested by our data, namely, whether the single (unmarried) state is intrinsically more pathogenic for men than for women. Of course, to answer this question definitively would require a longitudinal study of the two groups, matched in mental health composition when they were crossing into the marrying age. According to our present formulation, the Midtown bachelors and spinsters, far from being so matched, by social selection processes have been differently "loaded" in mental health composition, even among their youngest (age 20 to 29) element. And these loadings have been so heavy

as to obscure any differential effects, specific to the single state, among men and women.

Moreover, we would venture the hypothesis that if there are such differential effects specific to the unmarried state they would in the main tend in the direction of greater situational stress for women than for men originally of like mental health condition. This postulate is suggested by the probability that the compensations for lack of a family life, such as are partially provided by a career, may be intrinsically smaller for women than for men. Furthermore, unmarried women are handicapped by the cultural fact that theirs is a more restricted, insecure, and anomalous role in the extrafamily social spheres to which they must look for their major compensations.

/Seeming to support this hypothesis are the indications that unmarried career women predominantly remain ready at the "drop of the right hat" to pick up the full role of domesticity. A national sample of young women (age unreported) were asked: "Which would you rather be if you had a choice: be unmarried and have a successful career; be married and have a successful career; be married and run a home?" Of the employed single women in this sample, only 7% chose the first alternative, another 20% the second, and 70% the third.[23]

Seeming to contradict this hypothesis, on the other hand, is a finding of the Bellin-Hardt community study of mental health among the aged in a New York upstate city.[24] With their criterion of mental morbidity, these authors report almost identical rates for unmarried men and women in the covered age range (65 and over). However, let us assume that interlocking in-migration and emigration selection processes during the young adulthood of these subjects had been such as were postulated above, namely, leaving these spinsters, as a group, originally of better mental health composition than the bachelors. If so, the present *like* mental morbidity rates of the single men and women would suggest the possibility of greater deterioration among the latter since their younger adult years. Should this turn out to be the case, it would of course support the hypothesis that the unmarried state by and large may entail greater deprivational handicaps for women than for men.

From the single people we might next turn to the widowed, who appear in any numbers only among the sample females. And even here we are compelled to merge the age 30 to 39 and 40 to 49 groups[25] for comparison with the age 50 to 59 widows. For such comparative purposes let us take the sample wives of like age as our point of reference.

Premature loss of the wife role, through death of husband in the middle years of life, would certainly qualify as a situation of discontinuity in vacating a highly invested social role. We could therefore plausibly expect this role transition to belong to the order of accidental, crisis events that tend to catalyze latent mental pathology toward more

overt forms of malfunction. This expectation seems to be strengthened in the finding of the Bellin-Hardt[26] investigation that the widowed (in their age population) of both sexes had higher morbidity rates than did the still married.

However, processes of psychosocial selection can also be expected to complicate the picture among Midtown widows. To the extent that wives' personalities are directly or indirectly involved in hastening their husbands' deaths, prior to the latter event such wives might have differed in mental health from the generality of wives. However, it seems unlikely that the net differential between the two subgroups would have been large at that time.

More important, we hypothesize, is the selection process that determines which widows remain in Midtown and which leave the area. Usually, with loss of husband's income and the high cost of Manhattan housing, a widow could remain on the Island only if she had a self-supporting career, adult children capable of supporting her, or an independent income.[27]

If those widows who can meet the special requirements of remaining in Midtown are also in mental health respects a more favored group than those who depart the area, then this would reduce the difference in mental health composition previously postulated between the widowed and married categories of women. When Table 10-3 is considered, we observe that this seems to have happened.

Table 10-3. *Home Survey Sample* (Age 20–59), Proportion of Impaired Respondents among Widows and Wives of Like Age

	Age groups	
	B-C. 30-49	D. 50-59
Widows	27.6%	26.9%
N = 100%	(29)	(52)
Wives	20.0%	30.6%
N = 100%	(291)	(134)

In neither age column is the difference in impairment rates statistically significant. Nor, we would add, are the widows and wives different in their scatter among the other mental health categories.

Remaining for consideration is the divorced contingent, sufficiently represented in the Midtown sample only within the 30 to 49 age range. For purposes of comparison, Table 10-4 places this group's mental health distribution beside that of the married of like age and sex.

Table 10-4. *Home Survey Sample* (Age 20-59), Distributions on Mental Health Classification of Married and Divorced Respondents (Age 30–49 Only) by Sex

Mental health categories	Males		Females	
	Married	Divorced	Married	Divorced
Well	24.8%	4.0%	19.2%	7.0%
Mild symptom-formation	37.8	36.0	39.9	19.3
Moderate symptom-formation	18.1	20.0	21.0	31.6
Impaired	19.3*	40.0*	19.9†	42.1†
N = 100%	(254)	(25)	(291)	(57)

* $t = 2.5$ (.02 level of confidence).
† $t = 3.6$ (.001 level of confidence).

As was found in the Bellin-Hardt study,[28] the Midtown divorced of both sexes have the highest mental morbidity rates of all four marital status categories. In fact, these are the highest rates of any demographic groups reviewed to this point. The differences between the married and divorced groups in both Impaired and Well frequencies are well within the limits of statistical confidence. The ratio of Impaired to Well, roughly 1:1 among the married people of both sexes, is 6:1 among divorced women and 10:1 among divorced men.

The elements that probably converge to produce the standout morbidity rates among the divorced of both sexes seem to be more complicated than those for any other marital status group. These factors may be briefly outlined in terms of the following probabilities:

1. When adults cross into the marriage relationship, those to undergo divorce are already less favorable mental health risks than the subgroup who will remain firm in their marriage.

2. For some, divorce itself entails a crisis or role break that can be a trauma no less shattering than widowhood. For others, however, it may signify liberation from a potentially destructive predicament. In such cases, divorce would be a eugenic rather than a pathogenic development.

3. Age at divorce is usually younger than age at widowhood. Thus, the divorced more often remarry. The residual group of divorced (after this sorting process) would likely be even less favorable in mental health composition than before.

4. Unlike the widows, the female divorcees, healthy or otherwise, can usually maintain themselves in the area through supporting alimony and, having fewer dependent children, through supplementary employment.

We believe, all in all, that the selection processes (1, 3, and 4 above) cumulatively contribute most to the exceptional mental health distributions seen among the divorced males and females in Table 10-4, especially as the specific consequences of divorcement are by no means in a uniform direction.

By way of recapitulation, a significant relationship with mental health was found for age as an independent factor, but not for sex. When marital status was taken as a reciprocal demographic factor, in conjunction with sex, and age was controlled, significant differences in mental health composition were observed (1) between unmarried men and women, (2) but not between husbands and wives, (3) between the divorced and married of both sexes, (4) but not between widows and wives. The operation of various kinds of psychosocial selection processes was hypothesized to account for the sex differences in morbidity rates within a given marital group and for the marital status differences within one or both sex groups. The effects of these selection processes hamper the effort, in a cross-section study, to assess the discrete mental health consequences of the several marital states.

Left for future longitudinal research is this general hypothesis, which the present cross-section study could not test: Sociocultural differences in adult sex roles operate in such fashion that for unmarried people of like mental health the specific subsequent mental health impact of any given marital state tends to be less favorable for the female group than for the male. This hypothesis is prompted by a more general postulate; namely, if two groups in a society stand to any degree in a controlling-controlled relationship, then the dominant group of the two would tend to have greater access to defensive resources for protection against the potential ravages of role crises.

HELP-NEED AND THE PATIENT-HISTORY VARIABLE

Our second interest in this mental health tour of the demographic factors is focused on their relation to the behavior of coming under the professional care of a psychotherapist.

On this variable, we have surveyor "fixes" from two different sources of data. The first source is our Treatment Census operation, here necessarily limited to Midtown's combined clinic and hospitalized (under five years) patients. Expressed in treatment prevalence rates based on the total Midtown population in each marital status group,[29] we found, by way of brief summary: (1) higher rates among the unmarried than among the married people, which hold for both sexes on all adult age levels; (2) in the unmarried group, higher rates for males than for females; (3) in the married group, almost identical rates for the two sexes.[30]

However, such rates are of uncertain significance unless they are calculated in relation, not to the total population in a given group, but to the smaller population that satisfies the criterion of present morbidity or illness risk. For this purpose, we can return to the Home Interview Survey where the Impaired category in the mental health classification serves as the Midtown psychiatrists' approximation of this criterion. From the sample respondents we also know whether they have ever been in a professional relationship with a psychotherapist, however brief or extended. This is our criterion of patient-history.

Narrowing the focus from the sample as a whole to the Impaired respondents severely limits our analytical possibilities. Nevertheless, we have been able to divide these respondents into a younger (20 to 39) and an older (40 to 59) group, to subdivide these by sex, and to further subdivide the two sexes into single and now married—producing eight subgroups in all. The over-all lifetime ever-patient rate among the Impaired respondents is 26.7%. Among seven of our eight Impaired subgroups the ever-patient frequency does not vary significantly from this per cent figure. However, among the Impaired younger single males we find a patient rate of 57%. This contrasts with the 31% patient frequency of the Impaired like-age husbands and with the 22% of the Impaired like-age single women. In both instances the difference is statistically significant above the .05 level of confidence. Given that the younger Impaired bachelors are only 30 in number, we can push the analysis no further toward isolating the factors which might explain their unusually high patient rate.

This isolated subgroup excepted, we can infer that given an impaired level of mental health, men and women, married or unmarried, on the whole tend to have had recourse to a psychotherapist to about the same extent during their lifetime.

In short, when mental health (impairment) is held constant, the patient-history variable is unrelated to the sex and marital status factors. But since the Impaired frequency is itself higher for single males than for single females or married males, they would predictably also contribute most, in relative terms, to Midtown's present patient population. This prediction, based on the data of our Home Interview Survey, seems to be borne out by the data reported earlier from our Treatment Census operation. In Midtown at least, marital status is the only demographic factor on which differences of current patient rates happen to parallel the differences in over-all prevalence of mental morbidity. With the treatment procurement variable more or less uniform, differences in over-all morbidity rates *are* reflected by corresponding differences in patient rates. Whether this coincidence is a general or purely local phenomenon remains an open empirical question.

SUMMARY

Data from the Midtown community sample have here served several related purposes:

1. They have provided a basis for illustrating how exceedingly complex are the links between marital status, as a demographic variable of the reciprocal type, and present mental health.

2. In the light of these complexities, they have indicated the difficulties besetting attempts to draw etiological inferences from the findings of a cross-section study.

3. Toward longitudinal studies designed to isolate the specific effects of different marital states for those previously of like mental health, they have suggested a number of testable hypotheses relating to sex differences in sociocultural stress impacts.

4. They have illuminated that, at least in Midtown, particularly high prevalence or risk of mental pathology is to be found among single men and the divorced of both sexes.

5. They have revealed that given mental pathology, patient rates on the whole do not differ between the single and the married of either sex. However, given the greater frequency of such pathology among the single men, the latter proportionately contribute the most to the patient loads of psychiatric hospital and clinic facilities.

FOOTNOTES

[1] M. Mead, *Male and Female,* 1949.

[2] *Chronic Illness in a Large City: The Baltimore Study,* 1957, p. 97.

[3] W. F. Roth and F. R. Luton, "The Mental Health Program in Tennessee," *Am. J. Psychiat.,* vol. 99, pp. 662–675, March, 1943.

[4] Needless to say, this statement in no way precludes the possibility of significant intersex differences in syndromic types of mental pathology.

[5] Unless otherwise indicated, we shall hereafter use the term *divorce* generically to cover separation as well.

[6] One study of hospital patients attempted to test a hypothesis in which marital status was formulated as an independent variable. The difficulties in generalizing from the test data to this hypothesis are illustrated in the study report. See L. M. Adler, "The Relationship of Marital Status to Incidence of Recovery from Mental Illness," *Social Forces,* vol. 32, no. 2, pp. 185–194, December, 1953.

[7] These differences in age composition, unless taken into account, would of course result in impairment rates spuriously low for the unmarried and spuriously high for the widowed.

[8] This is an analytical procedure known as holding constant or controlling a factor (in this instance, age) that may obscure or distort the relationship of a second factor (in this instance, marital status) to the study's dependent variable—in this instance, mental health.

[9] This can prove to be the case, of course, although there is no difference between the two sexes as inclusive groups.

[10] The married category throughout this report will exclude the separated.

[11] None of the male-female differences in the four columns of Table 10-1 is statistically significant by the norm of an .05 level of confidence or better.

[12] Irving Rosow, "Issues in the Concept of Need-complementarity," *Sociometry*, vol. 20, no. 3, p. 223, September, 1957.

[13] The *single* rubric throughout this report will include only the never married (as reported by each respondent).

[14] However, on the age 30 to 39 level the impairment-rate difference of single females and wives nears statistical significance at the not unrespectable .07 level of confidence. Here the wives are also, in large part, relatively new mothers (see discussion in Chap. 9).

[15] On all age levels, the differences between unmarried males and unmarried females are statistically significant at the .001 level of confidence. It should be added that these men and women do not differ significantly in their proportions classified in the Moderate or Mild forms of symptom formation. Residually, on every age level the single women, as compared with the single men, have substantially higher proportions in the Well category of mental health.

[16] This is not to imply that the psychiatrists were unmindful of the potential psychiatric significance of nonmarriage for *both* females and males who were over 30. The fact is that singleness in the middle years of life carried weight in their mental health evaluations only when it was accompanied by other more credible signs of disturbance and disability in interpersonal functioning. For them, in short, nonmarriage was *in itself* not a sign of disturbance or a criterion of impairment.

[17] S. S. Bellin and R. H. Hardt, "Marital Status and Mental Disorders among the Aged," *Am. Sociological Rev.*, vol. 23, no. 2, p. 158, April, 1958. The locus of the investigation was an upstate New York urban community.

[18] One such deviation would almost certainly be insufficiently expressed career ambitions. Girls in a national sample of high school students were asked what outstanding qualities they would prefer most in a husband—after honesty and physical attractiveness. At the very top of the list, preferred by 46% were "brains," by 54% "sense of humor," and by 82% "ambition." H. Cantril (ed.), *Public Opinion, 1935–46*, 1951, p. 431.

[19] One local newspaper columnist has recently referred to this type as "the odd stick—not disliked, but not sought after; not rejected, just ignored."

[20] Of this type the same columnist notes that "her 'brain' may frighten even intelligent young men off. . . . Her basic need may continue to center on finding a male mind and personality more forceful than her own." However, of this kind of "male animal" the woods are scarce, and the wily trappers are many.

[21] The literatures of fiction and autobiography often highlight the maiden aunt, usually as a second, *albeit eccentric*, mother. The bachelor uncle is far more rarely portrayed, and then often as a family "stray sheep."

[22] Among the Midtown sample of single women as a group, about 25% are in professional or semiprofessional occupations, and 33% are holding middle-range managerial posts or relatively well-paid sales jobs.

[23] The balance of 3% replied "don't know." Cantril, *op. cit.*, p. 431. The 7% electing to remain unmarried provide an estimate of the frequency of the self-chosen type among single women.

[24] S. S. Bellin and R. H. Hardt, *op. cit.*, p. 158.

[25] It will be remembered from Chap. 9 that these two age groups, over-all, were quite similar in their mental health distributions.

[26] Bellin and Hardt, *op. cit.*, p. 158.

[27] Taking another husband is also a possibility. However, this seems to be a relatively small likelihood in an area with a large surplus of younger single women. Nationally, only 30% of widows marry a second time.

[28] Bellin and Hardt, *op. cit.*, p. 158.

[29] These population totals were in part derived from United States census reports, published and unpublished, and in part from estimates based on our random sample of Midtown's adult population.

[30] The widowed and divorced are represented by too few patients for reliable calculation of rates.

CHAPTER 11 *Socioeconomic Status: Specifications*

Leo Srole

In many human societies, both simple and complex, the typical family is saturated with awareness of its relative "position," "standing," "station," or "status" in the communal scheme of social rank. There are few places where this is more evident as historical fact than on the American scene.

Writers in the literary vineyards, from Chaucer to Faulkner and Marquand, have been arrested by the individual's predicaments in the halter of social status. On a higher level of abstraction, the concept of social class has engaged social philosophers and sociological theorists at least since Plato and Aristotle. Historians like Charles and Mary Beard and analysts of American culture ranging from Alexis de Tocqueville to Max Lerner[1] have given it a central place in their observations.

Among the field research disciplines, anthropology from its beginnings has more or less systematically taken into account the patterning of social rank in societies other than our own. The research record of sociology on this front is rather less consistent. Starting in 1889 Charles Booth, the English sociologist, published his six-volume research monograph *Life and Labour of the People in London.* A pioneer work of ground-breaking significance, its natural history purpose was "to describe the general conditions under which each class lives." In contrast with its large influence on the social work field here, the Booth monograph found only slight resonance in the research interests of American sociology.[2]

Although exploring all manner of social problems associated with poverty and fruitfully mapping various facets of the heterogeneous city as a community type, American sociological research by and large did not fully awaken to the systematic and dynamic implications of social class processes until two empirical developments emerged under principal impetus from the field of anthropology. These took form (some forty years after Booth's first volume) in the *Middletown* studies of the Lynds and in the *Yankee City* investigation launched by Lloyd Warner in 1931, with the present writer as a coworker and coauthor.[3] These two studies

had immediate and telling impact in directing American sociology's diverted attention to social stratification as a major specialty field of inquiry. By way of delayed recognition, a massive literature has sprung up in the field, one probably suffering at this point, as some have suggested, from "the disease of over-conceptualization." [4]

Given this current circumstance, the dilettantish becloudings of recent best-seller books on the subject, and the key importance of socioeconomic status (SES) to the present Study, the writer is prompted to indicate in brief compass the particular formulations, conceptual and operational, that guided his treatment of this complicated demographic variable while planning the design of the Midtown investigation in 1952. This effort, undertaken primarily for readers other than social scientists, will probably be better served if it starts with elementary processes discernible from the broad anthropological perspective.

FUNDAMENTALS OF SOCIOECONOMIC STATUS

Human societies all utilize the biosocial factors of age, sex, and marital status in order to harness individuals to the conjugal family as it advances in the processional of generations. Within a given society, furthermore, family units are often categorized on various sociocultural criteria that operate to sort them along various axes of subgroup formations. Socioeconomic status is one of these axes. At the root of SES differences the world over are the commonplace facts that (1) to meet its creature needs, the family must perform a productive work role within the local economy, and (2) the economy is organized around a division of labor, often manifested in technically specialized work roles or occupations that elicit and channel different kinds of individual skills.

It is axiomatic that the larger the diversification in occupations, the greater is the range of individual skills called into play. Although from society to society there are differences in the evaluation of corresponding occupations and the skills required, each society itself tends to place varying values on the several kinds of occupations represented in its own economic system. Such evaluations are usually expressed in the dissimilar "returns" associated with different occupations, returns both tangible and intangible. The intangible returns take the form of differential respect and esteem, carrying the force of community consensus, and ranging from prestige commanding great behavioral deference to stigma seen in opprobrious behavior toward the pariah.

Of course, there are direct consequences of the differences in both types of returns. For example, varying tangible returns imply differential capacity to acquire consumer goods and services in the form of creature necessities, amenities, and luxuries. In American society especially, the highly visible level and style of family consumption or standard of living,

although more or less dependent on the occupation that supports it, is itself one of several scales applied by the community in assaying the relative standing of different family units. In fact, the visible pattern of consumption, among other more basic motivations, is the family's most direct mode of symbolically validating the income value attached to its breadwinner's work role.

The varying returns of different occupations, both intangible and tangible, have further consequences (1) in the privileges and restrictions their holders are dealt and (2) in the relative control—through influence and power—that their occupants can or cannot exercise over community processes affecting the interests and well-being of their families. Thus family, economy, and polity interweave to form a closely knit trinity in the local social system.

Interfamily similarity of income and consumption is usually reflected in the spatial arrangement of housing areas, tending to make for residential contiguity and interaction of families in like economic circumstances. Such proximity, in combination with (1) similar life interests, problems, outlooks, and attitudes arising from like economic circumstances and (2) similar standing as status[5] equals, together tend to make for close associations, beyond those of kinship, in friendship circles characterized by relatively intimate behavioral congruence. In the nation's capital, by way of illustration, we are told that "Federal employees move socially within their own salary brackets." As has been observed about a lady who has lived in the District of Columbia for a long time, "everyone she knows has an income within a thousand dollars of her husband." [6]

Through overlapping memberships, these friendship circles are interlocked in an extended chain or network linking most families in the community who are in broadly similar economic circumstances. To the outside observer, this network can be seen as a loosely structured, informal kind of horizontal band, or status equivalents grouping. From the inside vantage point of the family unit, this grouping tends to be seen not as an inclusive whole, but rather as a series of three expanding, progressively less clearly delineated, concentric social rings. Bounding the innermost ring is the friendship circle or circles in which the family directly participates. In the next ring are the circles whose member units are partially known and defined as "friends of our friends." In the outer ring, the largest of the three, are the many other families of similar standing which, under the necessary face-to-face conditions, would normally be considered "socially our kind" and thus potentially eligible for friendship formation.[7] These three rings comprise a partially and loosely integrated social orbit and status category, which is locally identified in various ways, descriptive or metaphorical. Illustrative of such modes of identification for one particular status category are such terms as "high and mighty" "top drawer," "upper crust," and "the cream."

Marking off families in different status categories are divergences in standards of consumption, in values and tastes, and in behavior patterns and group identifications. As a result, there is comparatively little interaction between such families; in fact, there may be actual avoidance.[8] When interaction happens to be unavoidable or required, this "distance" is manifested as a rule in relatively brief and formal behavior.[9]

The community's several horizontal categories of families that differ in status relate to each other in a higher-lower or vertical rank order continuum. These ranked categories have been variously referred to as strata, status levels, socioeconomic groups, social classes, etc.[10]

Thus, from the twin processes of occupational specialization and differential economic and social evaluation of occupations there emerges a third process, i.e., varying elaboration of status groups and categories based on the family as their fundamental unit and arranged in a stratified order designated as a social class system.

In an earlier period of European history, the class system was of the *closed* type, marked by lifetime fixity of family position within one or another of three sharply cleavaged categories or "estates," namely, peasantry, burghers, and nobility. Through processes of evolution and revolution, the American version of the system has emerged into one preeminently, but by no means completely, *open* to change of family position. However, the broad lines of the three estates remain discernible in the apparent behavioral distinctions (1) between the manual worker (or blue-collar) class and the white-collar classes, and (2) among the latter, between the "middle" class and the "top drawer" families of inherited or acquired wealth and power.

In certain well-studied, older American communities, each of these strata has discernibly proliferated an upper and lower segment that Warner and his associates, the writer included, have viewed as social class groupings in their own right. However, economic changes within families and fluidity in friendship circle formation tend to make it difficult, both for community residents and scientific observers, to identify firm lines of demarcation between certain of these more limited groupings. As Lerner has more generally remarked: "To draw the profile of the American social strata is more elusive than almost anything else in American life." [11]

Apparently, we have here something roughly analogous to the chromatic spectrum of light with its bands of well-defined primary colors, the latter blending into each other at their margins to produce the secondary colors. That a continuum of shadings, rather than a series of lines, characterizes such a spectrum does not place in question[12] the identity or identifiability of each color, secondary or primary, despite its indistinct borders.

THE METROPOLITAN SITUATION

In the case of the SES spectrum, this kind of difficulty, although real enough for the field investigator, has become grossly exaggerated in the generally cogent literature of theoretic criticism. A far more serious difficulty to this investigator was the fact that the documented picture we had available on the structure and dynamics of the status system had been derived almost entirely from studies of small and relatively stable communities in New England, the South, and the Middle West regions. We had impressionistic reasons to believe that this picture applied in the main, if with touches of caricature, to the metropolis of Washington, D.C., where rank (and its well-publicized salary tag) in the huge bureaucracy of Federal government, as in the military hierarchy and in the one-industry town, is ordinarily coded and directly translated into parallel social circle clusterings and rankings of families. In contrast with such rigid patterning of status groupings in the exact mold of the economic and power hierarchies, we had the definite impression that in industrially heterogeneous metropolitan cities, like New York and Chicago, the face-to-face processes of status evaluation, friendship circle crystallizations, and resulting group formations are rather more diffuse and fluid.

One facet of this difference has been noted in the following observation:[13]

> In small towns of the United States, where every man may know almost every other, participation in the daily life of the community is widely evaluated. On the basis of such community-wide evaluations the participating person and his family may be assigned to a social class. . . . In contrast to the intimate and enduring appraisals of the small town may be placed the anonymous and often fleeting appraisals of the city [where] many social contacts are segmented and the participants often strangers. Consequently, the urbanite may frequently rely upon appearance rather than reputation: status may be temporarily appropriated by the "correct" display and manipulation of symbols.

Our procedural detour around this problem can be more appropriately summarized in the instrumentation section below.

CONCOMITANTS AND CONSEQUENCES OF STATUS DIFFERENCES FOR THE CHILD

We have sketched the functional evolution of social rank systems out of fundamental economic and regulative (power) processes into varyingly circumscribed but interlocking clusters or groups of informal interpersonal associations.

Around the base of similar economic roles, resources, and capabilities[14] each of the several social class groups elaborates its own standard of consumption, a more or less coherent framework of values and attitudes,

a congruent set of behavior tendencies, and common patterns of intrafamily functioning. These form a constellation, or way of life, that, together with variant constellations in other groups, are often conceived as related subculture designs[15] within the larger cultural tapestry of the community.

For us the decisive point about each status group and its way of life is that it is also the form and content of the child's "little world"—the environment, intrafamilial and extrafamilial, that guides, channels, and marks his personality development with its own indelible stamp, as it were.

The second volume of this monograph focuses on certain highly specific experiences of our Midtown sample respondent and tests their connections on the one hand to social class differences and on the other to the mental health variable. Here we turn to several larger concomitants and consequences of status differences that impinge with particular force on the child and seem to provide preliminary conceptual sightlines to the connections between the socioeconomic patterning of the child's world and his subsequent mental health.

An inventory of differences among children belonging to the three broad bands (i.e., lower, middle, and upper) of the American status spectrum could list research-documented items in the hundreds. For present illustrative purposes, we shall confine ourselves to only a few of these, selected because they represent relatively recent research or conceptual developments that seem to be of large potential significance.

One set of important SES corollaries is suggested by William Osler's famous observation that "tuberculosis is a social disease with medical aspects." Medical epidemiology has long established that certain infectious and deficiency diseases are inversely correlated with socioeconomic status. Recently, a similar relationship has been uncovered for the prevalence of chronic disorders.[16]

Whatever the etiologies of the several genera of somatic diseases, for children in different status environments they pose varyingly discriminatory risks of illness and disability, with potential sequelae of atypical personality development. The cumulative effect of these differential risks on physical survival alone may be inferred from the fact that between newly born white children of highest and lowest SES parents the latter infants have an average life expectancy *7.6 years fewer* than that of the former.[17] If the individual survives to the twentieth birthday, the chances of being dead by the twenty-fifth birthday are four times greater for the low-status person than for his status opposite.

Of particular relevance here is this reported finding:[18]

> . . . there are positive and probably etiologic relationships between low socioeconomic status and prenatal and paranatal abnormalities which may in turn

serve as precursors to retarded behavioral development, and to certain neuropsychiatric disorders of childhood such as cerebral palsy, epilepsy, mental deficiency and behavior disorder. . . . Interestingly enough it was not the mechanical factors associated with difficult and operative deliveries which were implicated, but rather the non-mechanical factors such as toxemias and hypertensions of pregnancy, bleeding during the third trimester and prematurity.

Striking here is that the chain of organic malfunction of mother leading to obstetrical complications and neurological damage of child seems to be traceable to a socioeconomic locus. The specific conditions responsible have not yet been identified, but there are suggestions that they may be partially rooted in nutritional deficiencies.

A large literature testifies to SES-mediated differences in malfunctions within the child's interpersonal realm. With the interrelationships of father and mother one of the pillars in this domain, Goode cites evidence supporting the observation that "economic factors may be of importance in marital stability." [19] This supplements research confirming that maladjustments in husband-wife relationships increase in prevalence downward on the social class scale.[20]

The frequent deterioration of such maladjustments into broken homes has been repeatedly noted in the literature: "Lower class families exhibit the highest prevalence of instability of any class in the status structure. . . . In the Deep South and Elmtown, from 50 to 60 percent of lower class family groups are broken once, and more often, by desertion, divorce, death or separation . . . between marriage, legal or companionate, and its normal dissolution. . . ." [21] Evidence on the psychiatric effects of such broken homes has now been comprehensively reviewed by Gregory.[22]

This carries us to the all-important parent-child dyad in the family structure. Since we must be highly selective, we shall not touch on the extensive series of studies bearing on specific infant training practices in the lower and middle classes but shall refer instead to several investigations which have focused on more global aspects of the parent-child relationship. Offering a suggestive portal to these aspects is a study reporting that middle-class children tend to feel themselves influenced in their behavior by parents perceived as a pair, whereas to lower-class children these influences are more often felt to be emanating from parents as separate individuals.[23]

For the latter child, apparently, the father-mother bond tends to be less an entity and more a case of "house divided." The potential implications of this interparental fracture for the personality of the growing child would seem to be considerable.

To a sample of 1,472 adolescents, Nye has applied a measure of child-parent adjustment. He finds that "adolescents from the higher socio-

economic level families score higher [i.e., better] on feelings of being loved and secure, feelings that parents trust and have confidence in them, socialization including disciplinary relationships [i.e., more positive feelings about parents as disciplinarians], attitudes toward the parent's personality and . . . adjustment to groups outside the family." [24]

If these findings are worded in terms of children from lower-SES families, implied is a greater prevalence there of a fracture in the parent-child relationship. This inference is consistent with projective test data among lower-SES "normal" samples, where subjects "portray themselves as relatively isolated from parental figures whom they see as cold and rejecting." [25]

From his research in a lower-class metropolitan area, Miller observes: "The genesis of the intense concern over 'toughness' in lower class culture is probably related to the fact that a significant proportion of lower class males are reared in a predominantly female household, and lack a consistently present male figure with whom to identify and from whom to learn essential components of a male role. Since women serve as a primary object of identification during preadolescent years, the almost obsessive lower class concern with 'masculinity' probably resembles a type of compulsive reaction-formation." [26]

Employing "family rituals, as a relatively reliable index of family integration," Bossard and Boll [27] assert: "Our overall conclusion is that family rituals increase in number, variety, richness and willing cooperation by individual family members as one moves upward in the economic scale."

These sociologists see the lower-class family as having "little connection with the past. The present is composed of individuals crowded into a space too small for comfort. . . . Children see little if anything in their families to stimulate a desire to perpetuate what they see. Opportunities for emotional satisfactions in the home are few, even for adults. The rituals arising from these situations are, for the most part, rituals of expedience, to keep the home going, and to facilitate escape. . . ."

In the middle-class families, on the other hand, "the tone is one of hopefulness and optimism. . . . The rituals here show a cooperativeness, of a desire to reach these goals, as well as a genuine family 'togetherness' in a home where there is need and opportunity for it."

In a paper appropriately titled "Portrait of the Underdog," [28] Knupfer "considers the disadvantages of low status, the restriction of 'life chances' which low status carries with it. From this point of view, the tendency of different aspects of status to 'cluster' together takes on the aspect of a vicious circle which recalls the Biblical dictum: 'to him that hath shall be given.'" Knupfer then offers evidence "to show that closely linked with economic under-privilege is psychological under-privilege: habits

of submission, little access to sources of information, lack of verbal facility. These things appear to produce a lack of self-confidence which increases the unwillingness of the low status person to participate in many phases of our predominantly middle-class culture, even beyond what would be a realistic withdrawal adapted to his reduced chances of being effective."

The matter, we consider, goes much deeper than a lack of self-confidence. The child of the slum, to concretize the urban version of low status, tends to find in his home few responses to his need to feel that he is valued or respected.[29] The self-image initially implanted in that important arena of his life, we can assume, is hardly a prepossessing one.

To an even lesser degree does he find this response outside the home—with the single exception of his street gang (wherein lies its potent hold on him). In a study of school children Neugarten[30] reports that "social class differences in friendships and reputation are well established by age eleven years." Lower-class children, this investigation revealed, were regarded with indifference or disfavor by school mates of higher status, and even more strikingly, they regarded themselves unfavorably. Moreover, they enjoyed no surcease even when they escaped to their movies and comic books. In Hollywood films, "whether by omission or commission, there is an implicit but clear disparagement of anything that suggests 'dirty work' or anyone who labors. Such deprecation pervades all the popular culture media, assailing the worker (and his children) and tending to weaken his ego-image. . . ." [31]

The selected pieces of evidence just reviewed, among many others, all fit into a consistent picture. This picture reveals a life setting for the slum-level child heavily weighted with impoverishing burdens and deprivations of body, mind, and spirit, to an extent well beyond the more nurturing environment of the middle-class child and far beyond that of the "cushioned" upper-class child. However, what is perhaps the most serious core of the matter has not yet been brought into sharp focus. In fact, this was only partially discerned when the Midtown Study was being designed.

The keystone of the democratic creed is the doctrine that, whatever their native endowments, all men are intrinsically of equal worth before God, the law, and their fellows. With considerable intensity, children tend to incorporate this canon as a bulwark in their still fragile image of themselves. As we have seen, however, in many areas of his experience the lower-class child encounters the contempt, implicit but palpable, in the nonverbal behavior of others who think of him in the symbolism of such words as rubbish, scum, dregs, riffraff, and trash. These devastating judgments inevitably force their way into his own self-evaluation processes. Thus, he is caught between grossly contradictory, mutually exclusive images of himself, torn by a conflict implanted through

the agents of a society that professes equality and practices invidious discrimination.[32]

Between the millstones of this jarring contradiction, the slum-dweller child grows into another, if related, conflict. Under the democratic guarantee of equal opportunity he may expect, given the requisite ability and effort, to rise to a social position of more comfort and respect. But with economically and culturally disadvantaged parents and a school system unmotivated to help him overcome his learning lags,[33] he is likely to get only the legal minimum of ten years schooling. On the other hand, carrying no better native endowment but confronted with none of the objective barriers, his high-status schoolmate goes on to college. From that turning point forward the career opportunities are actuarially even more disparate than the differential longevity expectations of the two boys.

The "poor" boy has a large chance of becoming a factory hand, the "rich" boy a corporation executive. By all economic criteria, with support from all the culture media, the latter is a success, the former decidedly less than that. But under the logic of equal opportunity, this difference in terminus is presumed to reflect differences in character and abilities; q.e.d. the factory hand is inherently inferior to those in higher economic echelons. Thus the contrast between the open opportunities doctrine (seemingly validated by the successful) and his own meager career accomplishments is a second source of unresolved contention in the arena of his self-evaluation. Reinforcing each other, we hypothesize, the two conflicts have been induced at every step in the lower-class individual's life by a self-contradicting society, one that regularly feeds and uplifts him by the promise of its tenets as democratic writ and that just as regularly cuts him down by the punishing inequalities and discriminations of its social class system. This, it is submitted, is a culturally designed approximation of the classical experiments in provoking animals to the point of immobilization.[34]

In a trail-blazing paper, Merton has delineated the disparity between culturally emphasized goals and socially inaccessible means to actualize them, a sociological condition of disjunction or *anomie,* and one he demonstrates to be highly conducive to behavioral deviation.[35]

The present writer has elsewhere conceptualized these phenomena of social conflict as one stream among others leading to the individual state of self-to-group alienation or *anomia,* and has shown that the frequency and intensity of this state vary inversely with socioeconomic status,[36] i.e., are most heavily concentrated at the lowest reaches of the social class scale. Parallel but more extensive data from the Midtown sample adults will appear in a separate publication by this author.[37]

Although not fully articulated to the social class framework, the work of psychiatrists Cleveland and Longaker[38] has recently made a conceptual

contribution in relating culturally derived value conflicts to the emergence of psychopathology. The intervening process of "disparagement" they locate

> . . . on the level of individual development and personality integration [as a] pattern of extreme devaluation . . . which can arise . . . when the socializing agents, primarily the parents, hold out contradictory models of behavior (grounded on conflicting cultural values). . . . Disparagement can become a fixed tendency in the child to devalue certain facets of his own personality. . . . Moreover, the disparagement of self is often not confined to one's own individual capacities but radiates to disparagement of the defined behaviors and value systems of his culture. In short, it touches all that has been internalized by the individual, or with which he identifies. . . . Its corrosive implications stem from both the tendency to deny individual worth, with resultant crippling of selfhood, and to deny the worth of group values, and thus to cripple interaction.

The quoted authors delineate this situational nexus in the neurotic processes of three psychiatric patients from a single extended family.

That the parents of the slum child may themselves be behaving under this self-defeating mechanism could account for the atmosphere of malaise often observed in such homes and for the affectional fractures discerned above in the father-mother and parent-child relationships. Given this kind of disarticulated family setting in infancy and early childhood, given the assaults on body, mind, and spirit in later childhood, and given the double-barreled, destructive conflict of self-image during adolescence, we can judge that chance and society have saddled on the lower-class child a particularly heavy and progressively mounting series of burdens. Compared to the more privileged child, we originally hypothesized that he and his peers, as adults, would be more defenseless against the crises of life and therefore more susceptible to mental morbidity.

INDEPENDENT OR RECIPROCAL VARIABLE

Applying this hypothesis to our Home Survey adults brought a further problem of specification. Most previous investigations focusing on mental health as the dependent or response variable had in effect declared, as had one, that "the class status of individuals in the society is viewed as the independent or antecedent variable." [39]

The present writer from the start rejected this view as untenable. At the very least, an adult's socioeconomic status and his mental health are *concurrent* phenomena and no basis exists for assuming a priori which is antecedent and which is consequence. Moreover, realities strongly argued that sound preadult mental health is generally a favorable precondition to achieving higher adult status, just as chronic mental

disturbance could make it difficult for a breadwinner even to match his parents' socioeconomic standing.

On the other hand, the adult's success or failure in meeting the standards of the SES group to which he is oriented may contribute its own discrete weight toward changing the subsequent course of his mental health development. As previously suggested, therefore, the adult's *own* status level must strictly be hypothesized as no more than a reciprocal variable relative to his current mental health.

For SES in a form that can be defended as antecedent to and independent of mental health we had to look to the status of the adult's *childhood* family, here designated as *parental SES* or *SES origin*, particularly as the weight of accumulated evidence suggests that (1) the childhood period may be crucial in shaping determinants of later mental health, and (2) interfamily differences may be partially attributed to differential social class patterning of intrafamily processes and life conditions.

INSTRUMENTATION: HOME SURVEY OPERATION

Estimation of parental SES among our Home Survey sample of adults in turn raised several technical problems. Ruled out as data altogether inaccessible to us were the subjective indications of social standing, namely, (1) how member families of the community say they place each other on the social rank scale and (2) where member families behaviorally place themselves through participation in selected friendship circles, secular organizations, and religious institutions of known SES composition. These involve rating methods that have been particularly developed and systematized by Warner in his techniques of "evaluated participation." [40]

Accessible, however, were the objective indicators that themselves contribute to the community's determination of family status. For example, toward classifying respondent's own SES we used four such indicators, namely, his education, occupation, total family income, and rent—as a key to his style and standard of family living. Such yardsticks would have been preferred in any case because they are quantifiable, are simple to secure, and readily lend themselves to comparative uses in different communities.

For respondents' parents, who in largest numbers had lived in places big and small spread over the European and American continents, across a time span of a half century, neither income nor rent offered itself as a sufficiently standardized register of interfamily differences. The father's schooling, on the other hand, was somewhat less objectionable, and his occupational level was most acceptable of all for this purpose. However, for interview elicitation from the father's offspring, the latter

datum in particular required a number of special precautions. First, for what stage of father's life did we want his occupation—at marriage, at retirement, at midlife? This could not be left to respondents to decide in their separate ways. And clearly it had to be specified at a stage that respondent could report from personal observation. Rephrasing the question in terms of respondent's age of observation suggested that we set this period at the *same* point in the life cycle for *all* respondents. The point we felt to be of maximum significance was the respondent at age 18 to 19, when he was near the launching of his own career and the father himself was probably near the middle of his work history.

Second, precautions had to be taken to minimize the widespread tendency to add a substantial dosage of wishful thinking in reporting occupations, both for the father and oneself.[41] Accordingly, three separate questions were put to each respondent with reference to occupation of himself and of his father. In relation to the father these were: (1) "When you were about 18 to 19 years old, what kind of work was your father doing for a living?" (Here the interviewer recorded the work as described and the title of the job if named.) (2) "At that time did he work for himself or others?" (3) "About how many people did he have working for (under) him?"

Placement of father and respondent, each in his own occupational bracket, was made neither by the respondent nor by the interviewer. Instead, on the basis of the respondent's three replies and a framework of specifications developed for the purpose, office coders placed the father in one of 27 occupational rubrics. The latter were then collapsed on the line of the blue-collar–white-collar dichotomy, with each category in turn divided into a high, middle, and lower grade. In the blue-collar range, these grades represented the usual skilled, semiskilled, and unskilled kinds of manual work.

Within the white-collar range the allocations were somewhat more complicated. Into the high stratum were placed professionals and top-level executives—self-employed and otherwise. Semiprofessionals, intermediate managerial personnel, and highly specialized sales people (e.g., in real estate, stocks, insurance, wholesale trade) were assigned to the middle grade. To the lower bracket were allocated small shop (goods or services) proprietors, managers with relatively few subordinates, other sales people, and office and clerical help.[42]

The six grades were given score values from 1 to 6 proceeding upward in the scale. Fathers' schooling was similarly divided into six grades.[43] For each father the two scores, equally weighted, were summated. The distribution of 1,660 summated scores was then cut in a manner to produce six groups as equally populated as possible. This stratification will be our measure of respondent's parental SES.

It is readily apparent that this is an unusual yardstick in two respects. First, the lines of demarcation between the parental-SES levels emerge from the procedure of distributing families in nearly equal numbers among the six strata. On the one hand, this is an approximation of defining classes by the criterion of equally spaced intervals; an instrumentally desirable tactic whenever it is feasible. On the other hand, it lends itself readily to symmetrical mergers into fewer and larger categories when SES-origin differences must be applied as an analytical control.

Second, the six parental strata do *not* tell us how respondents' families stood in the prestige rank system of their respective home communities. This, of course, would have been beyond the practical powers of retrospective research to reconstruct. Instead, they suggest how these families would hypothetically have stood *relative to each other*, in socioeconomic respects, had they all been gathered together, at one time and place, to continue functioning as they had when their offspring-respondent was near the turn into adulthood. In effect, therefore, these families as stratified represent an analytically contrived social rank order.

However, each of the six aggregations of respondent families may not be quite as artificial as would appear at first glance. It was the writer's prediction that when economically equivalent SES classes in different Western countries were ultimately studied and compared in detail, this would be found: The specific status-linked similarities in outlook and behavior patterns would outnumber and significantly outweigh differences rooted in specific national traditions. The rationale for this prediction was the assumption that like economic and creature conditions of life, in countries within the broad Western compass, tend to evoke similar constellations of values, goals, and role patternings in both intrafamily and extrafamily settings of daily functioning.

Monographic studies of this general kind have since been made in England, Australia, Mexico, and Soviet Russia. In a prepublication summary of the Soviet study[44] we are told: "It will perhaps come as a great surprise to many that there is a close correspondence between the pattern of experience and attitudes of Soviet citizens and their counterparts on the same level of education or occupation in a variety of other large scale industrial societies having markedly different culture and history and possessed of quite dissimilar political institutions." Despite extreme differences in methods employed, the three other studies point in the same direction.[45]

Accordingly, the respondent families in each of our SES-origin strata, with their close similarities in education and occupation, would probably have shared a wide range of other common elements. Such a larger array of like characteristics would support our inference that each stratum

of families has a core of homogeneity in intrafamily patterns, if not of interfamily linkages.

In moving on to the respondent's *own* status alignments we shall proceed on three separate tracks. First, for uniformity of yardstick in comparing parental SES and own SES, we have classified the respondent by *his* education and occupation, using the identical methods as with the father.[46] Second, to trace respondent status changes (mobility) from specific parental positions, we compare occupational level of father and of respondent. Third, to stratify respondent's own SES on the most refined and extended yardstick available to us, we have combined his total family income and dwelling rent with his education and occupation.[47] Each of the former two indicators was also cut into six brackets and scored on a 1 to 6 scale. The sum of the scores for the four indicators, all given equal weight, was calculated for each respondent. The sample's distribution of these summated scores was then cut to yield 12 segments, as evenly populated as possible. By this expanded measure we may be able to trace more exactly the shifting pattern of mental health distributions across the entire own SES range.

INSTRUMENTATION: TREATMENT CENSUS OPERATION

In our Treatment Census operation we faced certain other difficulties. Working exclusively from institutional records, we found that data related to parental SES were available, in the nature of the situation, only for preadults. This did not matter, since our interest in the treatment variable in any case allotted primary relevance to the immediate own SES circumstances and settings of patients as they crossed into a therapeutic relationship. It was here in fact that we encountered problems. In the records of psychiatric hospitals and clinics, information on income or rent appeared infrequently; for the nonemployed, including housewives, occupation of family breadwinner was often missing; and for 10% of the adults no data on schooling were given. From office therapists it proved possible to ask only for patient's name initials,[48] diagnosis, and home address. The latter item of information, in terms of verified residential buildings, was provided for 81% of the office patients reported to us. Together with home address of 99% of hospital and clinic patients, the largest possible common indicator of status we could apply to Midtown's patient population (as enumerated by our Treatment Census) was place of residence.

Other studies have given a rank order value to all homes in a small area unit with known economic characteristics, e.g., the census tract.[49] However, Midtown's extreme housing heterogeneity—even within the census tract subunit of the city block—made this expedient patently error-ridden. The only alternative, but this a difficult one, was to use the

individual residence as the unit of evaluation.[50] Fortunately, earlier in the Study a housing survey had been made (for the writer's Sociographic operation) by four volunteer businessmen[51] who were experts in local residential properties. Every tenanted building in Midtown was inspected by a team of two of these men and graded, by means of consensus judgment, on criteria of housing quality and condition of upkeep.

The validity of these judgments was later tested against the 1,660 Home Survey respondents. A Pearson coefficient of .73 was established between (1) the housing grades independently assigned to respondents' buildings by the above teams and (2) respondents' composite own SES scores as based on education, occupation, income, and rent. This is sufficiently high to warrant use of the former, divided into three categories, as a crude substitute own SES yardstick for our Treatment Census patients. As to the reported office patients of unknown address, we assumed that they were distributed among the housing categories in more or less the same manner as the office patients of known address. Actually, there may be a bias hidden in this allocation, to which we shall allude when the data are presented in Chapter 13.

It should be added that to calculate patient rates in each housing category, the denominator figures needed were the total number of people living in each such grade of housing. This the United States census could not furnish. However, we did know the housing grades and total number of occupants in 2,060 randomly selected Midtown dwellings. From this sample it was possible to estimate the total population in each housing category, thereby permitting computation of patient rates per 100,000 people in each stratum.

SUMMARY

Substantively, the contents of the present chapter belong in earlier Chapters 2 and 3. However, unusual complexities and difficulties attending observation and measurement of the SES variable dictated that this discussion be held as stage setting for the data chapters that follow immediately.

To capture the essential, universal elements of socioeconomic status, its genesis was traced to this chain of fundamental processes: proliferating social division of labor, occupational specialization, differential evaluation of occupations and differential rewarding of the skills they require, economic shaping of family conditions and style of life, and the interactional sorting of economically similar families into friendship circles and status-peer groupings.

Note was taken of the evolution of the medieval European status system, closed and sharply cleavaged in structure, toward the open spectrum type of contemporary America. However, formal research evi-

dence was lacking on status processes and class structuring in the American metropolis.

The concept of the status group's way of life as a constellation or subculture was advanced and tied to the patterning of the child's world. Selected research evidence was introduced to indicate social class differences in patternings that were potentially significant for the direction of mental health development.

Focusing on the slum child, a formulation was offered of the development of conflicting self-images and evaluations, induced by self-contradictions in the doctrinal and behavioral realms of a democratic but prestige-discriminating society. These and other impoverishments of the lower-class family and environment provided the rationale for the test hypothesis that in the Midtown survey sample parental socioeconomic status and adult mental health would be inversely related.

The grounds for the distinction between parental SES and own SES were defined. Discussed also were the various problems of and solutions to measuring socioeconomic status both in the Treatment Census and Home Survey operations.

FOOTNOTES

[1] For a highly perceptive discussion of the matter, see M. Lerner, *America as a Civilization*, 1957, pp. 465–540.

[2] C. H. Page, *Class and American Sociology: From Ward to Ross*, 1940.

[3] Robert Lynd and Helen Lynd, *Middletown and Middletown in Transition*, 1929 and 1937; and W. L. Warner, L. Srole, P. S. Lunt, and J. O. Low, *Yankee City*, 1941–1947, vols. 1–4. For a comprehensive account and balanced evaluation of the antecedents, contents, and repercussions of these community studies, see M. M. Gordon, *Social Class in American Sociology*, 1958.

[4] H. W. Pfautz, "The Current Literature on Social Stratification: Critique and Bibliography," *Am. J. Sociol.*, vol. 58, no. 4, pp. 392–418, January, 1953.

[5] For verbal convenience, the term *status*, when appearing without specification, will hereafter be used as shorthand reference to socioeconomic status.

[6] I. Kapp, "Living in Washington, D.C.," *Commentary*, vol. 26, no. 1, p. 61, July, 1957.

[7] Obviously other criteria of eligibility also operate. Some base eligibility on inherited family lineage, a symbolic badge that may be more weighty to a rare few than economic and related circumstances. Some criteria refer to group alignments that cut across and tend to subdivide the economically grounded status-peer grouping, e.g., religious affiliation and nationality background. Other criteria relate to personal tastes and interests that combine into a test of esthetic and intellectual congeniality, such as is conceptualized in Russell Lynes's (*The Tastemakers*, 1954) typology of "highbrow," "middlebrow," and "lowbrow."

Of course, such religious, ethnic, and esthetic criteria may draw together people of dissimilar economic characteristics, thereby interlacing and blurring the edges of adjoining economic-peer groupings. However, it is more often likely that such criteria will tend to recruit friendship circles from within, rather than from beyond, the same economic bracket.

[8] "Individuals occupying certain statuses simply do not directly interact with persons in certain other statuses, or interact only minimally. . . . A 'map' of the interaction patterns of most American communities would unquestionably show definite clusters

of frequent interaction, separated from other clusters by social voids only lightly bridged by a few individuals." Robin Williams, *American Society*, 1951, p. 522.

[9] "[One] type of [interstatus] insulation involves direct person-to-person interaction, but consists of formalized and limited patterns of relationships such as the constrained interaction of superiors and subordinates in rigidly hierarchical organizations." *Ibid.*, p. 523.

However, those serving people of different social ranks learn to modulate the formality of their behavior, as enlisted men reveal in their interactions with the various ranks of officers. Similarly, a Washington columnist reports that the capital "is a place where the grocer knows precisely the standing, social and financial, of Mrs. Jones against Mrs. Smith . . . and intuitively treats each good lady with the exact degree of deference to which she is entitled."

[10] In the interest of variety, we shall use these terms interchangeably.

[11] Lerner, *op. cit.*, p. 473.

[12] Implied in this question is the fallacy of discrete concreteness; that is, what does not have clear-cut boundaries does not qualify for identification as a conceptual entity.

[13] W. H. Form and G. P. Stone, "Urbanism, Anonymity and Status Symbolism," *Am. J. Sociol.*, vol. 57, no. 5, p. 504, March, 1957.

[14] One of the most complete research documentations of the economic and power aspects of the social rank system is to be found in A. Davis, B. B. Gardner, and M. R. Gardner, *Deep South*, 1941, pp. 255–539.

[15] The development of this concept in the work of the Lynds and Warner and his associates has been synthesized by C. Kluckhohn and F. R. Kluckhohn, "American Culture: Generalized Orientations and Class Patterns," in L. Bryson et al. (eds.), *Conflicts of Power in Modern Culture*, 1947, pp. 106–128. For related formulations see M. M. Gordon, "*Kitty Foyle* and the Concept of Class as Culture," *Am. J. Sociol.*, vol. 53, no. 3, pp. 210–217, November, 1947; W. H. Form, "Stratification in Low and Middle Income Housing Areas," *J. Social Issues*, vol. 7, no. 1, pp. 109–131, 1951; H. H. Hyman, "The Value Systems of Different Classes: A Social Psychological Contribution to the Analysis of Stratification," in R. Bendix and S. M. Lipset, *Class, Status and Power*, 1953, pp. 426–442; and W. B. Miller, "Lower Class Culture as a Generating Milieu of Gang Delinquency," *J. Social Issues*, vol. 14, no. 3, pp. 5–19, 1958.

[16] L. Breslow, "Uses and Limitations of the California Health Survey for Studying the Epidemiology of Chronic Disease," *J. Public Health*, vol. 47, no. 4, p. 171, April, 1957; J. M. Ellis, "Socio-economic Differentials in Mortality from Chronic Diseases," in E. G. Jaco (ed.), *Patients, Physicians and Illness*, 1958, pp. 30–36; and "Limitation of Activity and Mobility Due to Chronic Conditions," *Health Statistics*, United States National Health Survey, ser. B-11, p. 15, July, 1959.

[17] A. J. Mayer and P. Hauser, "Class Differentials in Expectation of Life at Birth," *Rev. inst. intern. statistique*, vol. 18, pp. 197–200, 1950.

[18] B. Pasamanick, H. Knobloch, and A. M. Lilienfield, "Socioeconomic Status and Precursors of Neuropsychiatric Disorder," *Am. J. Orthopsychiat.* vol. 26, no. 3, pp. 594–602, 1956.

[19] W. J. Goode, "Economic Factors and Marital Stability," *Am. Sociological Rev.*, vol. 16, no. 6, pp. 802–812, December, 1951.

[20] J. Roth and R. F. Peck, "Social Class and Social Mobility Factors Related to Marital Adjustment," *Am. Sociological Rev.*, vol. 16, no. 4, pp. 478–487, August, 1951.

[21] A. B. Hollingshead, "Class Differences in Family Stability," *Annals Am. Acad. Political Social Sci.*, November, 1950, pp. 39–46.

[22] I. Gregory, "Studies of Parental Deprivation in Psychiatric Patients," *Am. J. Psychiat.*, vol. 115, no. 5, pp. 432–442, November, 1958.

[23] F. Sabghir, *Relation between Consistency and Ego-supportiveness of Influence Techniques Used by Parent and Behavior and Self-acceptance of Children*, unpublished doctoral dissertation, George Washington University, 1959.

[24] I. Nye, "Adolescent-Parent Adjustment: Socio-economic Level as a Variable," *Am. Sociological Rev.*, vol. 16, no. 3, pp. 341–349, June, 1951.

[25] J. L. Singer, "Projected Familial Attitudes as a Function of Socioeconomic Status and Psychopathology," *J. Consult. Psychology*, vol. 18, no. 2, pp. 99–104, 1954.

[26] Miller, *op. cit.*, pp. 5–19. A study of London slum families uncovered the identical linkages; cf. B. M. Spinley, *The Deprived and the Privileged: Personality Development in English Society*, 1953, p. 81.

[27] J. H. S. Bossard and E. S. Boll, "Ritual in Family Living," *Am. Sociological Rev.*, vol. 14, no. 4, pp. 463–469, August, 1949.

[28] G. Knupfer, *Public Opinion Quart.*, vol. 11, pp. 103–114, Spring, 1947.

[29] In some part this may stem from the calculus of economic costs of a child relative to inadequate and unstable means and from the further fact that under lower-class fertility patterns children arrive far more frequently than they are wanted or can be accommodated into mother's economy of affect and energy.

[30] B. L. Neugarten, "Social Class and Friendship among Children," *Am. J. Sociol.*, vol. 51, no. 1, pp. 305–313, 1946.

[31] S. Bellin and F. Riessman, Jr., "Education, Culture and the Anarchic Worker," *J. Social Issues*, vol. 5, pp. 24–32, Winter, 1949.

[32] This happens, of course, not only between racial groups, but also within each racial group.

[33] W. L. Warner, R. J. Havighurst, and M. Loeb, *Who Shall Be Educated*, 1944.

[34] Cf. G. Murphy, discussion of "Irreconcilable Impulses," *Personality*, pp. 298–305, 1947.

[35] R. K. Merton, *Social Theory and Social Structure*, 1949, pp. 125–129. The writer's indebtedness to this paper is apparent. The deviation Merton refers to is "in types of more or less enduring response, not types of personality organization." Emphasized in the present formulation are effects on the ego mechanisms of the child's developing character structure.

[36] L. Srole, "Social Integration and Certain Corollaries: An Exploratory Study," *Am. Sociological Rev.*, vol. 21, no. 6, pp. 709–716, December, 1956.

[37] L. Srole, *Social Integration and Ego Functioning*, work in progress.

[38] E. J. Cleveland and W. D. Longaker, "Neurotic Patterns in the Family," in A. H. Leighton, J. A. Clausen, R. N. Wilson, *Explorations in Social Psychiatry*, 1957, pp. 167–200.

[39] A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness*, 1958, p. 12.

[40] W. L. Warner, M. Meeker, and K. Eells, *Social Class in America*, 1949.

[41] This is known to be maximized when the respondent is allowed to devise an occupational label of his own choice.

[42] In so stratifying the grades within the white-collar range, the writer was departing from the Edwards' United States Census scheme of occupational classification in the general direction taken by Warner's system (*Social Class in America*, pp. 140–141). However, in the absence of local evidence to indicate otherwise, we maintained the integrity of the blue–white-collar dichotomy, as had Edwards.

[43] That is, (1) some elementary school, (2) elementary school graduate, (3) some high school, (4) high school graduate, (5) some college, (6) college graduate. If father's schooling was uncertain or unknown, mother's schooling was used instead.

[44] A. Inkeles and R. A. Bauer, *The Soviet Citizen: Daily Life in a Totalitarian Society*, 1959.

[45] Spinley, *op. cit.*; O. S. Oeser and S. B. Hammond, *Social Structure and Personality in a City* [*Melbourne*], 1954; and O. Lewis, *Five Families*, 1959.

[46] However, wives are classified by composite score of own schooling and occupation of the husband.

[47] Tetrachoric correlations have been computed between sample respondents' occupation and (1) their years of schooling, (2) their family income bracket, and (3) their rental. The values of these coefficients are .77, .60 and .76, respectively. In a sample of Old Americans (age range unspecified) drawn in the Middle West town of "Jonesville," Warner found comparable coefficients of .77, .87, and .81, respectively. The latter value refers to the correlation of occupation and Warner's "house type" indicator (*Social Class in America*, p. 172).

[48] These were needed to check against multiple reporting of the same patient.

[49] The New Haven Study of psychiatric patients used a residential area scale of this kind, but the specific nature of the area unit employed has not been clearly identified. Hollingshead and Redlich, *op. cit.*, p. 390.

[50] See R. W. Mack, "Housing as an Index of Social Class," *Social Forces*, vol. 29, no. 4, pp. 391–399, May, 1951. Also, W. L. Warner, *Social Class in America, op. cit.*, pp. 143–150.

[51] These were Messrs. Kurt Porges, Percival Perkins, René Hoguet, and Jean Bloch, to whom the Midtown Study is indebted for this and other highly skilled services.

CHAPTER 12 *Socioeconomic Status Groups: Their Mental Health Composition*

Leo Srole and Thomas Langner

Change as it may, socioeconomic status is a lifelong motif in the individual's web of daily experience. One of the dominating designs in the vast tapestry of the nation's culture, it also weaves itself into the dreams, calculations, strivings, triumphs, and defeats of many Americans from childhood on.

Accordingly, the hypothesis linking frequency of mental illness to SES differences was inevitable, and indeed has drawn the attention of numerous investigations. Their reports provide convenient points of departure for the present chapter.

In largest numbers these researchers chose to test the hypothesis by the relatively simple expedient of enumerating psychiatric patients recorded on treatment rosters as their measure of the extent of mental morbidity. With several notable exceptions, these efforts did not explicitly distinguish between *treated* frequency and *over-all* (untreated and treated) frequency of mental illness as very different yardsticks of morbidity. They therefore applied the former but fell into the error of drawing generalizations as if they had measured the latter.

We hold that socioeconomic status linked on one hand to over-all frequency of mental illness and on the other to frequency of psychiatric treatment *among the sick* presents rather different situations that require discrete hypotheses and separate testing. In the next chapter we take up the SES-and-treatment hypothesis, where the previous studies of patient populations can claim direct relevance. To our top-priority hypothesis connecting status and *over-all* mental morbidity, these limited studies do not offer tests that satisfy the criterion of relevance.

Potentially offering a more adequate test of the latter hypothesis are the investigations that have looked beyond patients appearing on institutional records and, in search of both untreated and treated cases of illness, reached with a far wider, albeit crude, net into the lifestream

of a general population at large. Relatively few in number, these published studies deserve brief examination for any light they can throw on the present state of knowledge bearing on this particular hypothesis.

Probably the first and the largest of these was the National Health Survey conducted in 1936 under Federal auspices. Using the interview method and covering, in one of its aspects, a sample of 703,092 households (2,502,391 individuals) in 83 cities,[1] this study included a wide range of medical disabilities reported active on the day of interview. Included was the category "nervous and mental diseases," specifically "neurasthenia, nervous breakdown, epilepsy, chorea, locomotor ataxia, paresis, other diseases of the nervous system." Occupation was the SES indicator (among the employed in the age range 15 to 64) and was dichotomized on the line of the white-collar and blue-collar distinction. In frequencies of nervous and mental disease the data for employed females revealed no difference by occupation category. Among males, on the other hand, the white-collar rate of nervous and mental disease exceeded that of the blue-collar category by about 3:2.

A check of the latter finding is at hand in several wartime studies of Selective Service male registrants, with rejections for "mental and personality disorders" as the criterion of morbidity. One of these investigations involved a national sample clinically examined during November–December, 1943, with occupation again the status indicator.[2] With the exclusion of farmers, students, and the unemployed, no significant differences in psychiatric rejection rates were found among the several occupational categories there defined.

A second Selective Service study was conducted with 60,000 male registrants examined at the Boston Area Induction Station in 1942.[3] The Boston psychiatric rejection rates by socioeconomic level of registrants, as indexed by area of residence, were as follows:

Socioeconomic level	*Rejected in each level*
A (highest)	7.3%
B	9.2
C	9.4
D	10.0
E	12.7
F (lowest)	16.6

The most recent study relevant here is that conducted in Baltimore.[4] From our discussion in Chapter 8 it will be remembered that this investigation involved a clinical examination and evaluation of a sample of 809 men and women (approximately 30% of these were nonwhites) and covered a broad spectrum of some 30 somatic disorders. The mental disorder rates by income level are reported only for whites and nonwhites combined. If we assume that the nonwhites of Baltimore, as

elsewhere, are highly concentrated in the lowest of the four income brackets defined, then the other income groups, inferred to be predominantly white, have mental disorder rates reported as follows:

Income level	*Disorders in each level*
$6,000 and over	13.6%
$4,000–$5,999	8.9
$2,000–$3,999	8.9

The four inquiries just considered had in common the relatively rare feature of covering a general population rather than an aggregate of patients. However, on the issue of a connection between SES and over-all prevalence of psychiatric disability, the findings of these studies point in almost all possible directions. In the national Selective Service investigation the correlation was practically zero; in the Boston Selective Service survey it was inverse, i.e., the lower the SES level, the higher the morbidity rate; among the Baltimore sample whites it was apparently positive, i.e., highest morbidity rate in the top-income category; and in the National Health Survey the correlation was zero among females and positive among males.

Although the four inquiries used different SES indicators—occupation, area of residence, or income—these are standard measures that are known to be highly correlated with and predictive of each other. Accordingly, it is unlikely that the contradictory findings arise from the different socioeconomic yardsticks applied. Note in particular that the same index, occupation, was used in the two national investigations, yet divergent morbidity trends were obtained for the males in the two samples.

In the absence of sufficient evidence to explain or reconcile the inconsistent yields in the four studies reviewed,[5] the suggested hypothesis linking socioeconomic status and over-all mental morbidity in the general population can be viewed as an open question.

PARENTAL SES: MENTAL HEALTH DISTRIBUTIONS

During childhood, the individual shares the socioeconomic status of his parents and its many fateful consequences. This factor of SES origin we postulate to be an independent precondition related inversely to variations in adult mental health. We look to the Midtown Home Survey and its sample, representing some 110,000 adult "in residence" Midtowners, for a test of this hypothesis.[6] From the previous chapter it will be remembered that respondents' SES origins are distributed among six strata according to composite scores derived from their fathers' schooling and occupational level. With the SES-origin strata designated A through F in a sequence from highest to lowest position, Table 12-1

arranges the Midtown sample adults in each stratum as they are distributed on the gradient classification of mental health assigned by the Study psychiatrists.

Table 12-1. *Home Survey Sample* (Age 20–59), Distributions of Respondents on Mental Health Classification by Parental-SES Strata

Mental health categories	Parental-SES strata					
	A (highest)	B	C	D	E	F (lowest)
Well	24.4%	23.3%	19.9%	18.8%	13.6%	9.7%
Mild symptom formation	36.0	38.3	36.6	36.6	36.6	32.7
Moderate symptom formation	22.1	22.0	22.6	20.1	20.4	24.9
Impaired*	17.5	16.4	20.9	24.5	29.4	32.7
Marked symptom formation	11.8	8.6	11.8	13.3	16.2	18.0
Severe symptom formation	3.8	4.5	8.1	8.3	10.2	10.1
Incapacitated	1.9	3.3	1.0	2.9	3.0	4.6
N = 100%	(262)	(245)	(287)	(384)	(265)	(217)

* $x^2 = 28.81$, $5df$, $p < .001$.

Reading Table 12-1 horizontally from left to right in order to discern the nature of the trends, we might direct first attention to the Mild and Moderate categories. It is readily apparent that the frequencies of these two mental health conditions are remarkably uniform across the entire SES-origin range. These categories, it will be remembered, encompass more or less adequate functioning in the adult life spheres, although some signs and symptoms of mental disturbance in presumably subclinical forms are present. Equally prevalent along the entire continuum of parental SES, these two mental health types emerge here as generalized phenomena, much as they did with the age variable in Chapter 9.

We also note in the above table that around these numerically stable mental health categories the Well and Impaired frequencies vary on the SES-origin scale in diametrically opposite directions. From the highest (A) to the lowest (F) of the status groups the Well proportions recede gradually from 24.4 to 9.7%, whereas the Impaired rate mounts from about one in every six (17.5%) to almost one in every three (32.7%).[7]

These countertrends can be more efficiently communicated by converting them into a single standard value that expresses the number of Impaired cases accompanying every 100 Well people in a given group. In the Midtown sample as a whole, this Sick-Well ratio[8] emerges with

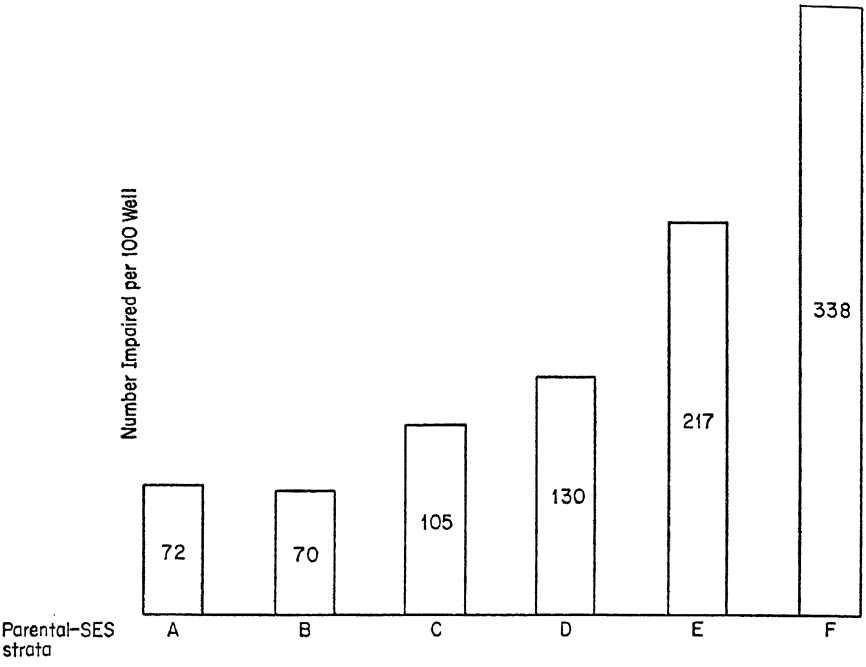

Figure 1. Home Survey Sample (ages 20 to 59). Sick-Well ratios of parental-SES strata.

a value of 127, a norm available for comparative uses in the pages to come. In bar chart form Figure 1 presents the Sick-Well values translated from Table 12-1.

With the top SES-origin levels (A and B) as our points of comparison, we observe in Figure 1 that the Sick-Well ratio is half again larger in the adjoining group C, almost twice higher in the D stratum, three times greater in the E level, and at a point of five-power magnification in the bottom (F) group. Phrased somewhat differently, the two highest strata (A and B) taken together constitute about 30% of the sample but account for 40% of the Well and for only 22% of the Impaired. On the other hand, the two lowest strata (E and F) taken together constitute 29% of the sample but account for only 19% of the Well and for fully 39% of the Impaired.[9] Through these variously expressed data a connection seems to be apparent between parental SES and mental health in Midtown's adults.

But before we accept such a conclusion, we must give precautionary consideration to this question: Could not the above differences be the result of biasing factors that intruded in the research process? Four major points of potential intrusion can be identified, namely, (1) selection of a sample unrepresentative in SES composition, (2) bias on the part of

the interviewing staff, (3) status-linked differences in reporting symptoms on the part of respondents, and (4) preconceptions about social class held by the Study psychiatrists. These error potentials are too serious to be briefly dismissed and too technical for lengthy digression here. Accordingly, they are being held for evaluation in Appendix H. In fine, that evaluation presents firm evidence indicating that two of the four potential sources of bias (1, 4) had left no discernible traces of intrusion. Another possible source (2) is unlikely to have contributed significantly to such error, and the fourth (3) probably operated in a direction to *understate* the SES differences seen in Table 12-1. On balance, therefore, the chances seem large that the connection observed between SES origin and adult mental health is authentic rather than a spurious consequence of biases brought out by the research process. If so, the data reported appear to offer an adequate test of the following hypothesis as originally stated: Parental socioeconomic status during childhood is an independent variable that is *inversely* related to the prevalence of mental morbidity among Midtown adults. However, the data produced do not support the hypothesis in its original form. Instead, they force its modification into a three-part proposition: the stated independent variable of parental SES is related (1) inversely to the frequency of the Impaired condition of mental health, (2) directly to the frequency of the Well state, and (3) not at all to the frequencies of the Mild and Moderate types of symptom formation.

The first part of this proposition asserts that successively lower parental status carries for the child progressively *larger* risk of impaired mental health during adulthood. For those who may hold reservations about the clinical identity of the Impaired category of mental health, the second part of the proposition refers to the asymptomatic state as beyond cavil the minimal form of good mental health; and it asserts that successively lower parental SES tends to carry for the child progressively *smaller* chances of achieving the Well state during adulthood.[10]

The above proposition attributes some share of responsibility for adult mental health to differences in family socioeconomic status during childhood. Notwithstanding respondents' real differences in parental SES, however, it is altogether possible that the decisive factors influencing their current mental health had occurred not during childhood but since they have become adults.

The only approximate test of this possibility open to us here is to isolate the sample segment that has most recently turned adult, i.e., the age 20 to 29 respondents, who, on the average, are only five years removed from the end point of the teen-age phase. If childhood factors associated with parental socioeconomic status carry little weight for adult mental health, then we would expect that among these youngest sample respondents the parental-SES subgroups will emerge with rela-

tively minor differences in Impaired and Well rates. For each of the three parental-SES "classes" [11] among the age 20 to 29 respondents the actual frequencies and the Sick-Well ratio are seen in Table 12-2.

Table 12-2. *Home Survey Sample* (Age 20–59), Distributions on Mental Health Classification of Age 20–29 Respondents by Parental-SES Classes

Mental health categories	Parental-SES classes		
	Upper (A–B)	Middle (C–D)	Lower (E–F)
Well	34.1%	21.4%	12.9%
Mild symptom formation	35.5	38.1	39.6
Moderate symptom formation	20.5	23.7	27.7
Impaired	9.9*	16.8	19.8*
N = 100%	(132)	(132)	(101)
Sick-Well ratio	29	82	154

* $t = 2.1$ (.05 level of confidence).

Table 12-2 shows that the theoretical possibility defined is not fulfilled. On the contrary, among these young people recently out of adolescence,[12] significant differences in Well-Impaired weightings are plainly tied to variations in SES origin. We can therefore plausibly infer that these differences were predominantly implanted during the preadult stage of dependency upon parents and were brought into early adulthood rather than initially generated there.

PARENTAL SES AND NATURE OF SYMPTOMS

We can here take certain limited steps toward eliciting clues about the qualitative nature of these differential implantations. From the technical discussion in Chapter 3 it may be remembered that the questionnaire used to structure the Home Survey interviews covered a number of symptom clusters or dimensions. Each dimension was represented by a series of specific question items, ranging from three to eight in number. The number of symptomatic replies that a respondent gives under each dimension can be expressed as a score, which permits examination of the SES-origin strata in their distributions on that score range. Without detouring systematically into all the quantitative details of such psychometric data, we can here indicate the general nature of their trends.

For example, one of these dimensions had reference to signs of tension and anxiety.[13] It can be reported that there were no significant differences in tension-anxiety scores among the six parental-SES strata. In all of these groups about 30% reported one or another of these symptoms, i.e., score

of 1, and another one-third acknowledged two or more symptoms in this series. It can therefore be inferred that tension and anxiety scores are a generalized rather than a status-linked phenomenon in the Midtown population. The same inference is indicated for the "excessive intake" dimension, which refers to partaking "more than is good for you" of food, coffee, liquor, or smoking—each asked as a separate question. Again, about one-third of the respondents in all parental-SES groups reported overindulging in two or more of the four forms indicated. (Some 23% of the sample replied affirmatively to the liquor question.)

However, on all other symptom dimensions there was a highly significant *inverse* correlation with SES origin; that is, downward on the parental-SES scale the symptomatic tendencies increased. This trend obtained on such types of somatization as appetite-stomach or vasolability disturbances, dyspnea, heart palpitations, frequent headaches, and back pains. The trend registered similarly on the energy-deficit dimension of neurasthenic symptoms and on the affect dimensions of depression and hostile suspiciousness. It was manifest in the series of behavioral signs suggesting self-isolating tendencies. The high inverse correlation also appeared on two character dimensions that, for the Study psychiatrists carried little weight in themselves as criteria of functional impairment, namely, rigidity and immaturity. Both of these suggest difficulties in impulse control.

Moreover, on the basis of interviewers' observations there were 41 intellectually retarded individuals apparent in the sample, ranging from 5.5% in the lowest parental stratum to 0.4% in the highest.

Finally, where the protocol evidence suggested a passive-dependent character structure or a schizophrenic thought process, these were also recorded by the Study psychiatrists. The former dimension was observed with a prevalence of 40% in the bottom parental stratum and only 15% in the top. The corresponding rates of the schizophrenic thought process were 7.8 and 4.6%, respectively, but this difference is not statistically significant.[14]

From an unreported number of clinic patients, we might recall that Ruesch[15] projected the following symptomatic tendencies to two of the major social classes in American society: "We can state that the lower class culture favors conduct disorders and rebellion, the middle class culture physical symptom formations and psychosomatic reactions. . . ." Even if the Ruesch sample of patients offered a basis for generalization about the universes of the American lower and middle classes, as it does not, the data we have reported above suggest that the corresponding parental-SES strata in the community sample of Midtown adults do not support that generalization. A more plausible interpretation of Ruesch's observations is that (1) rebellious lower-class individuals with "acting out" character disorders tend to be shunted to psychiatric facilities by ac-

tion of community authorities or agencies; (2) their status peers with psychosomatic reactions get strictly medical or no attention; (3) middle-class individuals with psychosomatic disorders tend to be referred to psychiatric out-patient services, generally on the advice of their own physician.

In all, among Midtown's parental-SES groups there appear to be no frequency disparities in signs of a schizophrenic process, in symptoms of anxiety and tension, or in tendency toward excessive intake. However, on all other pathognomonic dimensions covered there is evidence among these groups of consistent variation in frequencies of disturbances in functioning—intellectual, affective, somatic, characterological, and interpersonal.

PARENTAL SES, AGE, SEX, AND MENTAL HEALTH

A definite relationship between parental socioeconomic status and adult mental health, sound and impaired, has been tentatively established in Midtown. We emphasize the word *tentative* because the possibilities that this finding is spurious are far from exhausted. Beyond technical artifacts, the correlation observed would be spurious if it evaporates when a third factor is analytically introduced and controlled. In the chapters to follow we shall test the relationship to mental health of other independent demographic variables of the sociocultural type. In those chapters it will be systematic procedure to assess the multiple ties linking parental SES and other such factors to the Study's dependent variable.

As a first step in this direction we ask: What is the outcome when we analyze adult mental health simultaneously against parental SES, sex, and age? Chapter 10 noted that in the Midtown sample as a whole there are no significant differences between males and females in their mental health composition. This situation persists, we can report, when both age and parental SES are controlled; conversely, control of the sex factor does not affect the relationship of parental SES and mental health. In future chapters, therefore, we shall drop sex as a control variable in dissecting factors potentially entangled with mental health.

In Chapter 9, it will be remembered, we saw the Sick-Well ratio rise from 65 in the age 20 to 29 segment to 205 in the age 50 to 59 group. In the light of this clear trend, it may be that age is the dominant variable and that the observed correlation between parental SES and respondent mental health is a spurious result of the contingencies that (1) groups with low SES origins may be "loaded" with older people and (2) those of high SES origins are heavily weighted with younger people.

To test this possibility, Figure 2 has been prepared. And to avoid imposing undue burdens on the graph, only the Sick-Well magnitudes are there presented for each of 12 subgroups of respondents representing

a particular conjunction of respondent age and parental SES. Of course, with so many subgroups the number of Impairment cases in each is unduly attenuated. However, we emphasize again our interest in the *direction* rather than the *size* of the Sick-Well differences, especially when pressing our finite sample to its utmost analytic limits.

Inspection of Figure 2 reveals that on all age levels the Sick-Well values—with only one exception—are progressively larger downward on the SES-origin scale.[16] In short, the connection between parental SES and mental health persists when the age factor is held constant.

The reader may also wish to trace the age trend within like SES-origin classes. For example, proceeding from the youngest through the oldest subgroup within the upper-origin class (A–B), the Sick-Well ratios are 30, 70, 71, and 172, respectively. Within the lower-origin class (E–F), similarly, the corresponding values are 154, 200, 300, and 384, respectively.

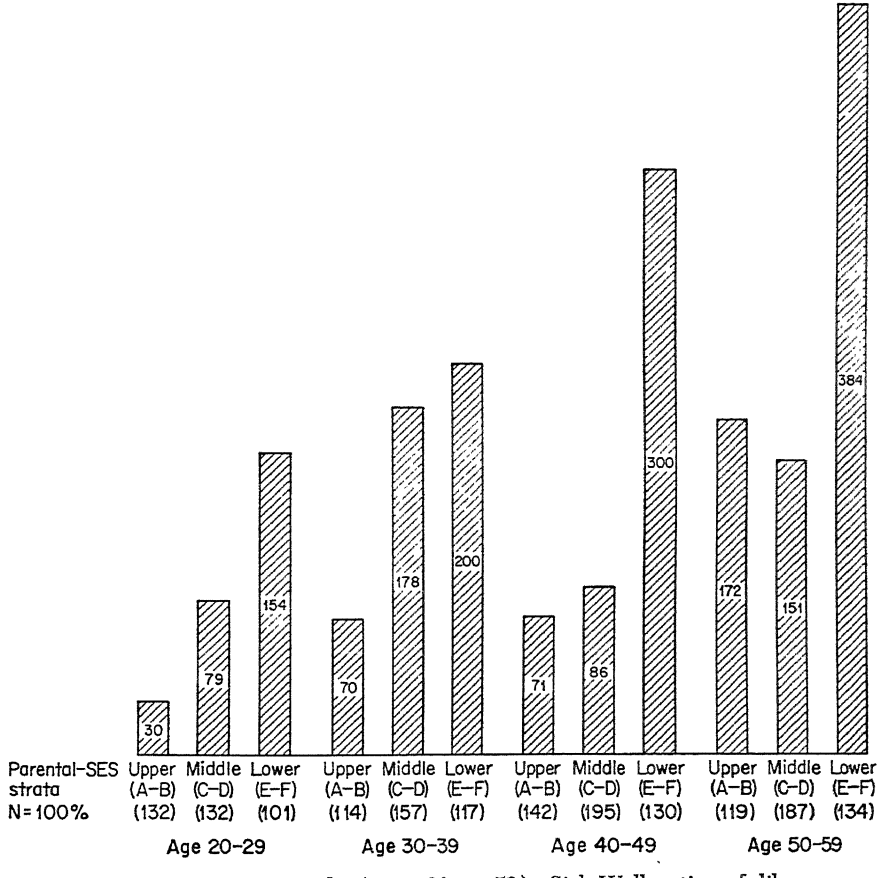

Figure 2. Home Survey Sample (ages 20 to 59). Sick-Well ratios of like-age respondents by parental-SES classes.

Finally, within the middle-origin class (C–D), the age progression shows values of 79, 178, 86, and 151, respectively. The trend-deviant subgroup here appears to be the age 30 to 39 respondents who, in fact, are quite close in mental health composition to their age peers of lower-class origin.[17]

We can summarize the two trends just disentangled with the single general statement that in the Midtown sample parental SES and respondent age are *both* related, quite *separately of each other,* to the frequencies of sound (Well) and Impaired mental health.[18] Stated in more dynamic terms, we can infer first that parental-SES differences were somehow involved in differential childhood implantings of potentialities for mental wellness and impairment. By the end of the teen years these susceptibilities were already differentially crystallized in the overt mental health conditions of the several SES-origin strata. Second, we can discern that subsequent progression through adulthood carries in its wake further precipitating or aggravating pathogenic effects for the vulnerable people *from all SES-origin groups.*

The power of the two demographic factors when joined together can be seen in the extreme contrast of Sick-Well values between the pair of most favorable variants, i.e., upper-SES origin and age 20 to 29, and the combination of most unfavorable variants, i.e., lower-SES origin and age 50 to 59. Among the former subgroup there are 30 Impaired cases for every 100 Well respondents; among the latter there are 384—a joint magnification power, by this measure, in the order of almost 13 times.

Given the "collaboration" of SES origin and age in their impacts on adult mental health, question arises about the generality of their interrelationship. And given that approximately three-fourths of Midtown's adults are migrants from beyond the City's five boroughs, might it not be that Midtown attracts migrants of a particular atypical kind—in whom the interlocking triad of SES origin, age, and mental health happens to be an idiosyncratic conjunction? On its face, this suggestion appears to be implausible but not impossible and therefore cannot be ignored.

To consider the question, we need of course the evidence of independent observation. Fortunately, three quite different shreds of evidence of this kind are available to be fitted together in somewhat the fashion of a jigsaw puzzle.

The first datum is this consensus estimate: "Practically all psychiatrists who have had extensive experience in working with college students agree that about 10% of the members of any institution of higher learning are likely to have emotional problems at some time or other during each year which interfere seriously with their work." [19]

In the Midtown sample, the closest single counterpart of the broad college population just referred to are the 132 age 20 to 29 upper-SES-origin (A–B) respondents. Included in this subgroup, as a matter of fact, are

29 current college or postgraduate students and five wives of such current students; among the remainder, most have attended or completed college training. It is therefore pertinent to recall that the impairment rate in this delimited age-and-SES subgroup is 9.9%.

The second source of evidence is a wartime study focused on white enlisted men who had not yet served overseas.[20] Used were one cross-section sample of 6,869 on-duty personnel and a separate sample of 563 psychoneurotic patients in Army hospitals. On the one hand, the latter represented mental impairment as judged by the criterion of behavioral incapacity for military duty. On the other hand, because of the constant surveillance and command powers of "noncoms," officers, and Army doctors these patients probably constitute a far closer approximation of over-all prevalence of impairment than do mental patients in civil life.[21]

The particular relevance of this investigation is to be seen in two of its aspects. First, it calculated the number of hospitalized psychoneurotics per 100 nonhospitalized men, producing a "PN ratio," which, in fact, suggested our own impaired-well measure. Second, it tested the variability of this ratio with age and education *simultaneously*. To be sure, a person's education is generally treated as an own-SES indicator, a precedent we ourselves followed. However, by reason of its direct dependence on, and high correlation with, parents' socioeconomic position, schooling level of offspring can also be considered as an alternative, crudely approximate, indicator of the latter.

In the Army study, the educational range was trichotomized into three levels, namely, high school graduation or more, some high school (short of graduation), and grade school only. In the 20 to 24 age group the PN ratios for these successive schooling levels were 29, 99, and 129, respectively. In the 25 to 29 age group the corresponding ratios were 51, 104, and 156, respectively. And in the 30-and-over age group they were 119, 214, and 284, respectively.

Thus, when age is held constant, the PN ratio progressively *increases* downward on the education scale; and when these ratios are rearranged to hold schooling level constant, they are found to *increase* progressively with each age increment.

The third source of evidence is the study conducted by Bellin and Hardt,[22] involving a noninstitutional community sample of 1,537 aged people dichotomized into two age groups, namely, 65 to 74 and over 74. The focus was *over-all* prevalence of mental morbidity, the latter as judged by "evidence suggestive of certifiability" to a mental hospital. With own SES,[23] in this instance dichotomized into a high and a low stratum, the morbidity rate was larger for low-status people than for those of high SES in both age groups and larger for older people than for those younger in both SES strata.

There are gross differences in the observed population segments just

cited and in the nature of the evidence drawn from them. Nevertheless, these varied pieces fit into a congruent pattern consistent with the Midtown finding that SES origin and age stand in separate but convergent relationships to adult mental health. Accordingly, this complex triad uncovered in the Midtown sample of adults gives the definite appearance of a general rather than a local or idiosyncratic phenomenon.

STATUS MOBILITY AND MENTAL HEALTH

We have thus far concentrated attention on *parental* socioeconomic status, postulated as embracing overarching constellations of different life conditions during childhood. However, there is a generalized cultural mandate binding all social classes in American society. Rising from impoverished immigrant parents to the summit of an industrial empire, Andrew Carnegie gave utterance to this mandate in ringing words: "Be a King in your dreams. Say to yourself 'My place is at the top.' " [24]

A more realistic injunction and one more widely accepted is this: Whatever your status inheritance from parents as a point of departure, strive to "do better," i.e., advance beyond it. In due course, the adult settles into his own position, at a level that may be higher, lower, or more or less the same as his father's. These three parent-offspring sequences are technically designated as the variable of *intergeneration status mobility.* The status mobility variable circumscribes an extremely complicated and dynamic set of processes that operate in the individual's life history between childhood under the roof of parental-SES conditions and his own status shelter built in adulthood for his spouse and children.

What light does published research shed on the mental health aspects of such mobility differences? In their recent literature-synthesizing book *Social Mobility in Industrial Society,* Lipset and Bendix[25] devote separate sections to (1) "the consequences of social mobility" for the individual and (2) varying individual orientations that spur different directions of status change. In the former discussion they conclude that "studies of mental illness have suggested that people moving up in America are more likely to have mental breakdowns than the non-mobile." An examination of the New Haven study used as the principal source of this inference shows that Lipset and Bendix appear to have misread the evidence. The New Haven reports[26] on status mobility covered 847 schizophrenics in treatment, who were found to be 88% nonmobile, about 4% upward-mobile, and 1.2% downward-mobile. (The remainder were in the category of "insufficient family history.") Contrary to the Lipset-Bendix reading, these data do not suggest a picture of upward mobility as a major trend among the New Haven cases. More important, even if their reading were correct, trends among treated schizophrenics, whatever their direction, can hardly be generalized to apply to treated nonschizophrenics (unreported in the

New Haven publications), or to untreated schizophrenics, or to the untreated with other disorders. Above all, these trends cannot be extrapolated, as Lipset and Bendix have done, to "mental breakdown" trends in the universe of "people moving up in America" as compared with trends in the universe of nonmobile Americans. In point of fact, there is now some question whether it is possible to extrapolate from the New Haven treated schizophrenics to schizophrenic patients generally. In a recent New Orleans study,[27] such patients were reported to be predominantly (45.7%) downward-mobile—in striking contrast with the New Haven cases.

In further fact, single point-of-time studies, whether of treated or overall mental morbidity, offer no basis for the inference that status mobility "may cause difficulties in personal adjustment." [28] Such investigations cannot parcel out the discrete mental health *consequences* of individual changes in socioeconomic status from the specific personality *preconditions* of different self-determined mobility paths.

However, citing the *same* New Haven treated schizophrenic rates, Lipset and Bendix assert[29] in their later section on differential motivations for mobility that "mental illness rates would seem to provide additional data for the notion that the upwardly mobile [population] tend to be deprived psychodynamically." In its context, this statement seems to suggest that psychic deprivation tends to induce status climbing. But clearly no study of patients can tell us about the psychically deprived and nondeprived segments of the nonpatient population and their respective mobility tendencies.

In a relevant research paper,[30] Douvan and Adelson preface their data report with the observation that in the large literature on social mobility

> . . . only limited attention has been given to studying the motivational sources of mobility. What we do find is a general disposition to treat *upward* mobility in a vaguely invidious fashion. It would seem that, in this country, the Horatio Alger tradition and the "dream of success" motif have been pervasive and distasteful enough to have alienated, among others, a good many social scientists. The upwardly aspiring individual has apparently become associated with the pathetic seeker after success or with the ruthless tycoon. This image of success is, much of it, implicit—assumption and attitude, and not quite conviction—but it seems to have dominated the thinking of our intellectual community.

In their insightful study of a national cross-section sample of 1,000 age 14 to 16 boys, Douvan and Adelson set out to test their ego-theory conceptualizations on personality determinants of precareer mobility aspirations. To draw on the summary of their findings:

> The upward aspiring boy is characterized by a high energy level, the presence of autonomy, and a relatively advanced social maturity. These attributes may be viewed as derivatives of a generally effective ego organization.

[In the] downward mobile boys . . . we see an apparent blocking or impoverishment of energy which should ideally be available to the ego. There is a relatively poor articulation among the psychic systems; impulses threaten the ego's integrity; the superego seems overly severe and yet incompletely incorporated. These boys seem humorless, gauche, disorganized—relatively so, at least. Perhaps the most telling and poignant datum which the study locates is their response to the possibility of personal change, their tendency to want to change intractable aspects of the self, and the degree of alienation revealed by their desire to modify major and fundamental personal qualities.

The study just reviewed was focused on mobility aspirations, among a general sample of adolescents, and their personality corollaries. As contrast to this prospective approach to adult developments, in the Midtown sample of adults we are focusing retrospectively on status mobility, completed or in process, and current mental health. In the planning phase of the Study we were clear that from the latter we could not dissect (1) what the level of mental health had been at the threshold of the respondent's career and (2) what increments of mental health change were subsequently added as a specific result of engagement in the struggle for own SES.

Nevertheless, in his 1952 proposals for the Midtown Home Interview Survey the senior author formulated a series of hypotheses[31] bearing retrospectively for each sample adult on the following nexus of forces: (1) respondent's choice of parental identification figure during childhood; (2) parents' agreement or disagreement in occupational hopes for and pressures on the respondent; (3) respondent's own occupational aspirations (upon completion of schooling) relative to the level of parental hopes; (4) respondent's current occupation relative to his end-of-schooling aspirations; (5) respondent's feeling of fitness for and strain in his occupation; etc. Although these dynamic dimensions of status mobility were all covered in the sample interviews for their relevance to mental health, they form a network too complex and specialized to have been incorporated in the analytic design of the present monograph. Accordingly, they are being reserved for future treatment in a separate publication by the senior writer:

On a more encompassable plane, we also postulated as follows:

1. Upward mobility requires not only appropriate aspirations but also efficient personal mobilization, such that to actually "make the grade," sound mental health is a decided preparatory asset and impaired health is not. Downward mobility, on the other hand, is culturally so deviant from group and self-expectations that it can only happen under some initial, predisposing handicap in physical or mental health.

2. In turn, given adequate preparation in the preadult stage, accomplished upward mobility and its rewards tend to have constructive consequences for subsequent adult mental health;[32] whereas the conse-

quences of downward mobility and its deprivations would tend to be in the opposite direction.

3. However, countervailing tendencies also operate. For some people, status climbing may have costly pathogenic effects that would have been avoided had they remained stationary, i.e., nonmobile, relative to father. Similarly, downward mobility may conserve or stabilize mental health in certain special, limited circumstances, when other courses would have been taxing or damaging to the individual.

As to the relative importance of these postulated elements in the resultant current mental health of sample respondents, we believe that those subsumed under hypothesis 3 are relatively rare and partially offset those suggested in hypothesis 2. The latter, in our view, are secondary to the dominant contribution of the forces emphasized in hypothesis 1, namely, the psychosocial selection of different kinds of preadult mental health for adult replication, advance, or retreat from parental status.

In testing the relationship of status mobility, as a reciprocal-type variable, to current adult mental health, we faced a number of alternatives in choosing a common yardstick to measure SES of both the respondent and his father. The decision finally taken was that for this specific purpose occupation level by itself, though not accounting for all socioeconomic variability, is more useful in identifying specific father-offspring sequences than any two status indicators arithmetically averaged. From the previous chapter it will be remembered that a series of three questions was used with each respondent to elicit (1) the nature of his own work and (2) that of his father when the respondent was age 18. On the basis of these data, father and respondent were separately placed within the identical occupational framework of six levels, numerically scored 1 to 6. Where respondent and father have a like score, the former is classified nonmobile. If the respondent has a higher score, he is classified upward-mobile, and if a lower score, downward-mobile.

It can now be reported of the 911 sample males and never-married females[33] who could be placed in terms of both father's and own occupation that their distribution among the three forms of mobility approximates a 1:1:1 ratio. However, the mental health compositions of these three groups present significant differences in the hypothesized direction, as Table 12-3 reveals.

We note first in Table 12-3 that the stable nonmobile group presents an even balance in its number of Impaired and Well members. With this as a point of comparison, we further observe that among the "climbers" there is an imbalance, with the Well outnumbering the Impaired by about 3:2. Finally, among the "descenders" the imbalance is tipped sharply to the other side, the Impaired exceeding the Well by almost 5:2.[34]

Table 12-3. *Home Survey Sample* (Age 20–59), Respondent Distributions on Mental Health Classification of Men and Single Women by Occupational Mobility Types

Mental health categories	Mobility types		
	Up	Stable	Down
Well	21.0%	22.6%	12.7%
Mild symptom formation	41.6	37.0	33.8
Moderate symptom formation	23.8	16.8	23.4
Impaired*	13.6	23.6	30.1
N = 100%	(315)	(297)	(299)
Sick-Well ratio	65	104	235

* $x^2 = 24.57$, $2df$, $p < .001$.

Two qualifications must be weighed for these trends. First, the relationship between occupational mobility and mental health would be at least partially spurious if the up-moving people were largely younger adults of higher status origins and those moving in the opposite direction were principally older adults of lower parental SES. The fact is that the climbers are split below and above the 40-year line exactly 50–50, whereas the descenders are split 40–60. Decidedly, the descenders *are* the older group. On the other hand, the climbers are predominantly (67%) from blue-collar fathers, whereas the descenders are mainly (55%) from white-collar fathers. Thus, the two potentially masking factors approximately serve to cancel each other out.

Second, our data may actually understate the strength of the relationship. An optimal test would focus on self-supporting adults at an age when occupational change is largely over, i.e., beyond the age of 40. Among younger adults, particularly in bureaucratic organizations, further reaches of work upgrading may still lie ahead. If so, mobility tendencies among younger adults would expectedly have a lesser linkage with mental health than among older people. This inference is actually supported by a comparison of the younger (age 20 to 39) and older (age 40 to 59) male and single women respondents. That is, the contrast in Impaired-Well balance between the upward- and downward-mobile types is considerably sharper in the senior than in the junior group.

We can look more closely at the character of the changes by focusing down to the 442 U.S.-born male respondents known in terms both of own and of father's occupation. This particular segment of the population is of purified relevance because it excludes the single women, who are limited in their occupational movements by an intracultural bias. Also excluded are the foreign-born males, whose mobility can be measured only by their occupational place in the American economy as compared

with their father's occupational level in the economy of the homeland. Here various intercultural biases probably operate.

We might start with the high white-collar level of business executives and professionals. Sixty-three fathers had been in this stratum. Of their 63 sampled sons, 33 established themselves in the some occupational bracket; the other 30 dropped to lower levels—several in fact to the bottom of the blue-collar range. However, more than offsetting the latter were 65 men who climbed into this stratum from fathers in lower occupations. (Fifteen of these men had blue-collar fathers.) Now let us consider the respondent mental health differences selectively carried in these shifts. To be emphasized is that the number of cases involved is small and accordingly the Sick-Well values are to be regarded as suggestive only. In Figure 3 the arrow indicates the direction of mobility (horizontal arrow signifies nonmobility), and the number in the circle attached represents the Sick-Well ratio of the men who moved in that direction.

As Figure 3 indicates, the healthier sons replicated their father's top occupational position. On the other hand, the less healthy sons more often moved down, to be replaced by far healthier men ascending from fathers at lower levels. Thus, all 63 sons of top-level fathers present a Sick-Well value of 70, whereas for all 98 men *now* in that occupational bracket the corresponding value is 24.

At the opposite pole is the unskilled class of blue-collar occupations. Fifty of our U.S.-born male respondents were from fathers at this level. Of these sons, 14 remain in the same kind of occupation; 6 of these have impaired mental health, 3 are well. Thirty-six other sons have climbed to higher points—14 to the low and middle white-collar strata, 6 to the

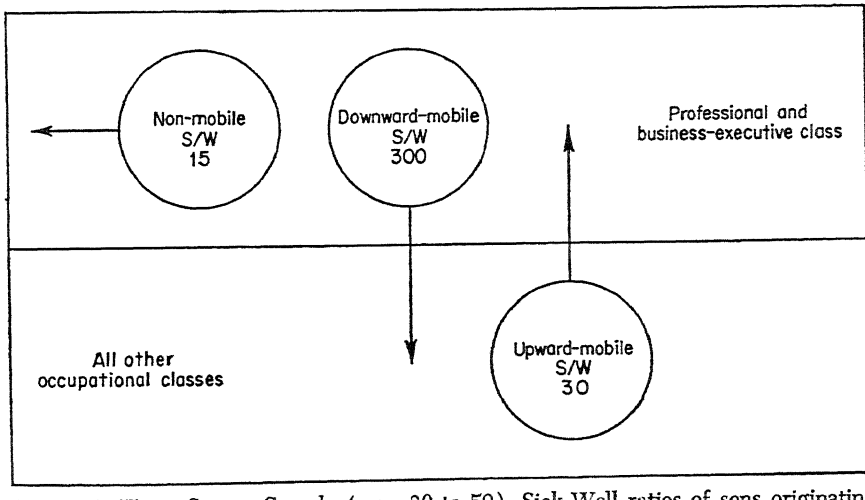

Figure 3. Home Survey Sample (ages 20 to 59). Sick-Well ratios of sons originating in or ascending into the top occupational class.

executive-professional ranks—and have an approximate balance in number of Impaired and Well respondents (Sick-Well ratio of 120). Replacing these climbers are 37 descenders from fathers in higher positions.[35] With the out-climbers healthier in composition than the nonmobile men and the in-descenders least favorable of all in mental health (Sick-Well ratio of 240), the 51 men now in the unskilled class have a Sick-Well ratio of 225. This compares with a value of 150 for the group of 50 offspring of unskilled fathers.

In the intervening occupational levels the mobility traffic is at once more balanced and more complicated. For example, there are 135 male respondents with fathers in the middle (managerial and semiprofessional) white-collar stratum. Of the sons, 65 (48%) were nonmobile, 46 (34%) were climbers, and 24 (18%) descenders. However, the latter two types of out-movers from the class were replaced by two types of in-movers, namely, 43 climbers from fathers of lower occupational standing and 26 descenders from executive-professional fathers. As net effect of these four-way counterbalancing movements, the mental health composition of American-born male respondents who *are themselves* in the middle white-collar category is little different from that of the group of men *deriving* from fathers who had been in this category.

We would emphasize again that the mental health differences reported for the three mobility types of respondents probably represent the convergence of two sets of factors: (1) original (preadult) mental health differences among those carried in different own-SES directions and (2) subsequent mental health shifts along the several mobility courses.

A longitudinal study design will be required to bridge the Douvan-Adelson data from adolescents and our own from Midtown adults. To such a prospective study, both sets of data offer the hypothesis that on the whole healthier adolescents tend to be more heavily drawn into the traffic of upward-moving adults, whereas more disturbed adolescents tend to be shunted into the downward traffic. We suggest the further hypothesis that on the whole those in the ascending traffic stream are subsequently less likely to show exogenous deterioration in mental health than those in the descending stream.

It may be asked how these hypotheses are to be articulated to the postulates in the previous chapter bearing on the child of low-status families. Among sample respondents derived from blue-collar fathers we know that about two in every five have been upward-mobile on our six-level occupation scale. Whether or not these Midtowners are in this respect typical of blue-collar offspring elsewhere is not yet known; but from evidence presented in Chapter 6 there are intimations that they may be more upward-oriented than their occupation peers elsewhere seem to be. Even here, however, the nonclimbers outnumber the ascenders. That

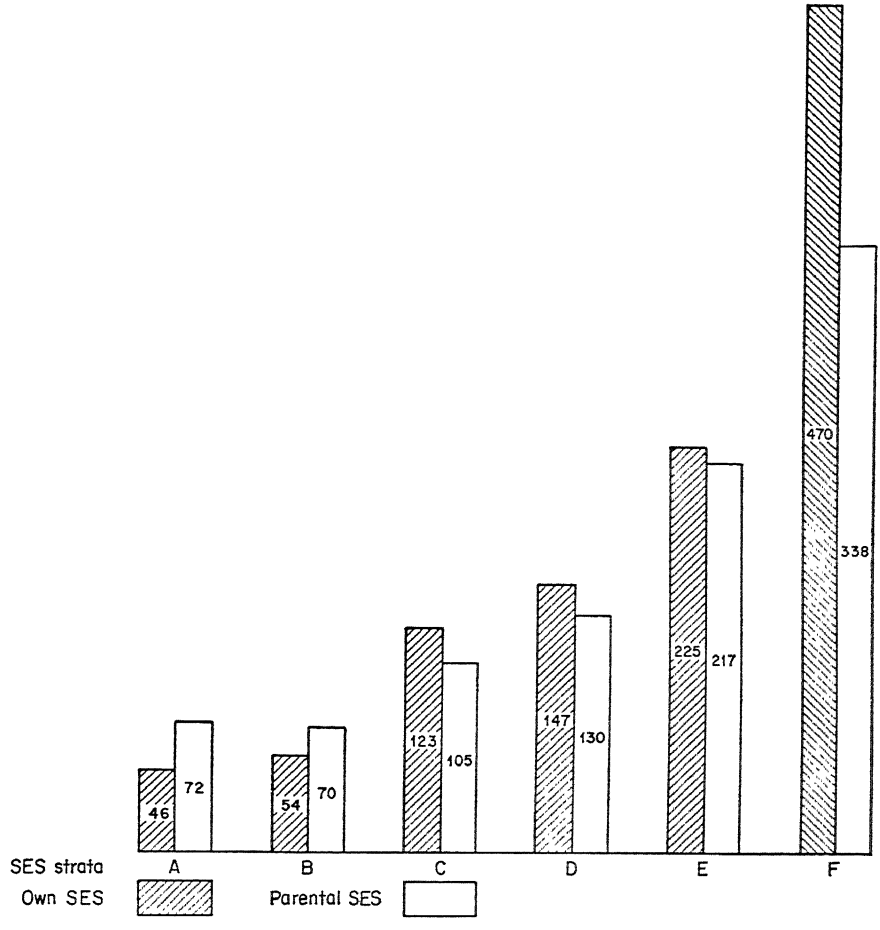

Figure 4. Home Survey Sample (ages 20 to 59). Sick-Well ratios of own SES and parental-SES strata.

there are climbers at all would seem to reflect two factors: (1) The dynamic New York economy has open places at the requisite occupational levels, and (2) the objective goads to escape to a more comfortable and respected style of life probably sort out the climbers from the nonclimbers along such personality dimensions as were delineated in the Douvan-Adelson study and were briefly sketched earlier in this chapter. The latter inference raises the further question whether differences in lower-class families yield personality variations among their offspring which issue in status-mobility divergences. It is this question which will be separately addressed by the Study's unanalyzed focus, outlined above, on the nexus of child-parent identifications and of congruences and conflicts in parent-child career aspirations.

OWN SES AND MENTAL HEALTH

From the unraveling of father-son occupational changes we can better grasp the results when the entire Midtown sample of adults are examined for mental health composition as classified on the scale of own socioeconomic status. In Figure 1 we charted the Sick-Well ratios of the sample arranged by SES origin as indexed by father's schooling and occupation. These are reproduced in Figure 4, but they now accompany bars representing the Sick-Well values of the entire sample when sorted by own SES as indexed by respondent's own education and own occupation.[36]

Reflecting the greater tendency of the Well to move upward and the Impaired downward, Figure 4 for the first time reveals that own SES stands to adult mental health in a relationship even more sharply accentuated than does parental SES. In other words, if parental socioeconomic status plays any contributory part in mental health determination, own SES tends to overstate the magnitude of that contribution.

For purposes of strict comparison of SES origin and own SES, we were compelled to apply to respondents the same two socioeconomic indicators as were available for their fathers. In order to obtain a more refined differentiation of respondent's own SES, we inquired about his family income and household rent as well as his education and occupation. From the sum of the scores on these four indicators, the sample was divided into 12 own-SES strata, as nearly equal in numbers of respondents as possible.

In the strata at the top and bottom extremes of this expanded range are 7.0 and 6.5% of the sample, respectively. Table 12-4 gives the complete distributions of these two sets of respondents on the Study psychiatrists' classification of mental health.

The Moderate and Mild categories of symptom formation aside, the

Table 12-4. *Home Survey Sample* (Age 20–59), Respondent Distributions on Mental Health Classification of Top and Bottom Strata in Expanded Own-SES Range

Mental health categories	Highest stratum	Lowest stratum
Well	30.0%	4.6%
Mild symptom formation	37.5	25.0
Moderate symptom formation	20.0	23.1
Impaired	12.5*	47.3*
Marked symptom formation	6.7	16.7
Severe symptom formation	5.8	21.3
Incapacitated	0.0	9.3
N = 100%	(120)	(108)
Sick-Well ratio	42	1,020

* $t = 6.0$ (.001 level of confidence).

mental health contrast between the top and bottom strata could hardly be more sharply drawn. The story is partially told in their Severe and Incapacitated totals (5.8 and 30.6%, respectively) and above all in their Sick-Well ratios.

Of even larger interest perhaps is the shape of the Sick-Well trend line across the entire range of the expanded own-SES continuum. This is profiled in Figure 5.

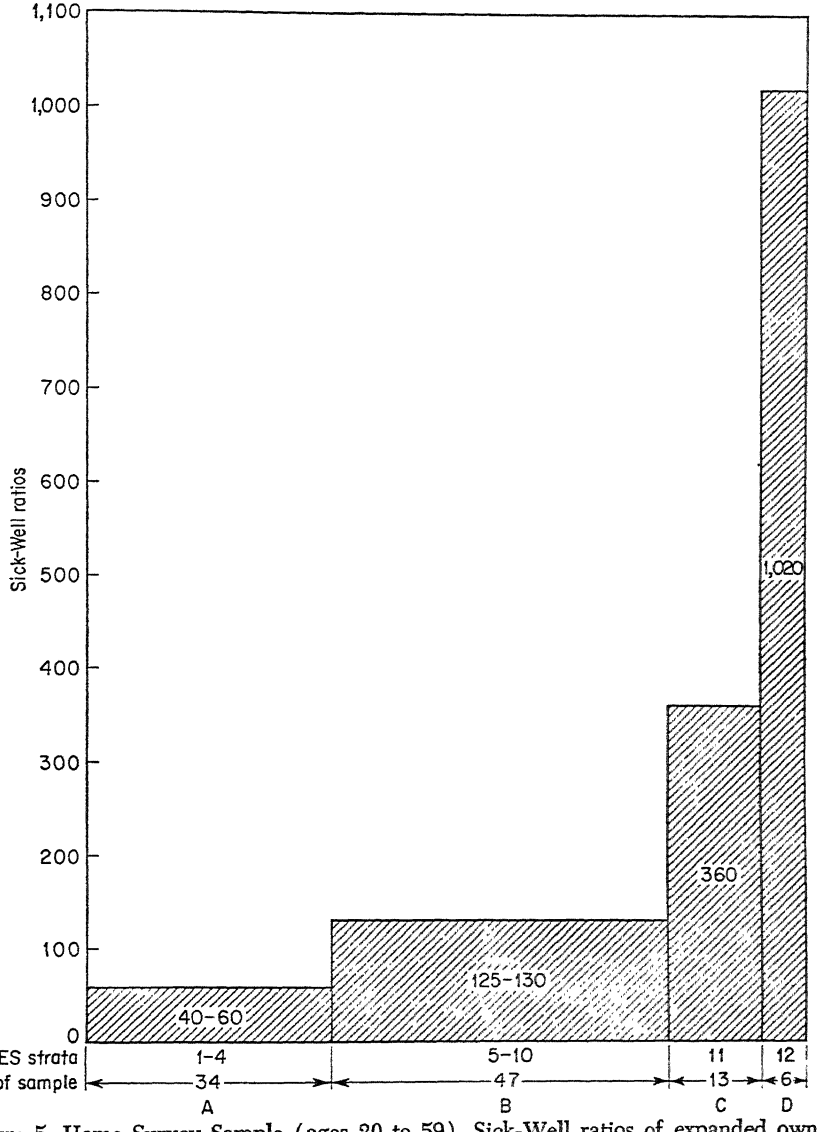

Figure 5. Home Survey Sample (ages 20 to 59). Sick-Well ratios of expanded own-SES strata.

Confronting the data that gave Figure 5, some investigators would defer to a statistical device (like chi square) for a yes-or-no dictum about the existence of a relationship between two variables, beyond that producible by chance, and consider their work done if the answer is "yes" at a given level of confidence. Since such an answer conveys nothing whatever about the relative strength or weakness of the relationship so affirmed, other investigators apply more specialized statistical devices to measure closeness of the correlation.

However, both kinds of statistical yardsticks are completely insensitive to something potentially important in the data which are given in Figure 5. That is, on the over-all spread of the trend there is a wide socioeconomic span (strata 1–4) devoid of any notable differences in mental health composition until a line of change is crossed. Rising to the 125 to 130 level at this crossing point, the Sick-Well ratio next remains in a flat trend across another broad span of own-SES differences (strata 5–10). These two large plateaus are followed toward the bottom of the own-SES range by two Sick-Well peaks (strata 11 and 12).

The precise extent to which Midtown's mental health distributions statistically vary with differences in own socioeconomic status is of negligible moment compared to this demand of sheer curiosity: Given that each of the graph's four SES zones has its own inner similitude of mental health composition, how can these segments be concretely identified? We have already seen that the adult own-SES groupings are the residues of rise and fall of status around the parental-SES points of departure. However, our present interest in identifying the four own-SES zones is directed not to their past but rather to their present life circumstances. These are large contemporary "worlds," we can assume, that are the scene or the source of morbidity-precipitating events for the more vulnerable people in their midst. On the basis of data culled for this volume we can indicate the approximate boundaries of these four worlds only in the most elementary economic terms.

In order of size, the largest is zone B, embracing strata 5 to 10 and roughly half of the entire sample. These six strata are quite uniform in mental health composition, with Sick-Well ratios that stand near the whole sample's value of 127. They are broadly spread across the lesser ranks of the middle managerial and semiprofessional occupations, through the lower white-collar, the skilled blue-collar, and the higher-wage ranks of the semiskilled factory workers. The family income span, in 1954 dollars, was in the main from $3,000 to $6,000, permitting a tolerable but hardly ample standard of consumption and certainly not permitting the accumulation of any significant reserve funds. With this "tightrope" living standard as the foundation of their claim to respectability, these respondents are close to the line of insecurity. When family crises jeopar-

dize the economic supports of this way of life, the strain placed upon personality resources may be great.

Since these people are numerically the dominant and psychosocially the pivotal segment in the Midtown population, they have a potentially large influence on the mental health climate of the community, above all at times of collective crisis.[37]

Noteworthy also is the large representation of blue-collar respondents in this zone. In recent decades they have caught up with the lower white-collar class[38] in both income and level of consumption and now also match their mental health composition. A tantalizing question they pose is this: Has their documented economic and social progress through these decades been accompanied by an unobserved improvement in mental health, i.e., improvement sufficient to close what had previously been an unfavorable difference? A ready source of evidence to answer the question is not directly apparent. However, the historical implications of a positive answer *are* immediately apparent, matters to which we will return in Chapter 18.

Second in sample representation (34%) are zone A's own-SES strata 1 to 4, covering the more affluent managerial and professional classes. Here we cross into a world characterized by a more secure, expansive, and ego-nurturing style of life with larger buffers or cushions against the inevitable abrasions and hard knocks of human existence. It is striking that above roughly $6,000 annual income further increments toward $15,000 and far beyond, with all the accompanying socioeconomic corollaries, do not appear to register any further gains in group mental health composition. However, it can be hypothesized that without the common denominator "prophylactics" of these strata their latent store of mental pathology would probably emerge in more overt and impairing forms.

At the other side of the own-SES range we find that zone C absorbs a relatively narrow 13% segment of the Midtown sample. Occupationally they are semiskilled workers in the City's newer, marginal low-wage industries and workers in the more stable forms of unskilled labor, e.g., domestics, sweepers, window washers, and janitors. Weekly family income may at times reach the $60 point but more often hovers around $50. Here, we move into a zone of "struggle to keep head above water." The entire style and tone of life bear the marks of strain from constant struggle at the edge of poverty. The mental health situation here is suggested by the spike in the Sick-Well ratio to the 360 point.

In zone D there is breakthrough to still another psychosocial realm, namely, poverty itself. Stemming in the main from parents in unskilled and semiskilled manual occupations, people in zone D are in or near the bottom bracket on every one of our four status indicators. Probably of first significance is that most of them did not complete elementary school.

For some respondents this default doubtless was determined by such exogenous barriers as extreme poverty, a disabled or departed parent, or an otherwise acutely deprived family; for other respondents the default may reflect childhood endogenous disabilities, physical or mental.

Whatever the specific source of the barrier, subminimal schooling on its own account sets off a chain of other restrictions: (1) restriction largely to marginal, temporary forms of unskilled labor; (2) restriction to a low, unstable income[39] that at best is beneath the minimal necessary to shelter, clothe, and feed a family (total income in zone D households almost without exception was in a range between $15 to $40 weekly); (3) restriction to cramped quarters in the most deteriorated slum tenements.

Such noxious life burdens, together with inadequate or vulnerable personalities developed in childhood, often combine to produce a break in the intolerable struggle. Chronic poverty has brought almost all zone D respondents to the City Welfare Department for financial assistance; and many belong to "multiproblem" families that are known to the police, courts, private social agencies, and mental hospitals.

From this group's mental health distribution reported in Table 12-4 above, it is seen that exceedingly few are Well (4.6%) and nearly half (47.3%) are Impaired. Segregated with others in like circumstances and mental health conditions, the numerically dominant Impaired of zone D doubtless help to create a "sick" slum community that often carries its own pathogenic "contagion," in particular for the children in its midst. It is hardly surprising, therefore, to hear of a 1956 New York City Youth Board Survey that covered 825 children of needy families and reported that 40% of these children manifest "serious behavior problems." It was predicted that another 10%, principally in the youngest segment of the sample, would likely develop such problems.

Here the frequency of adult mental pathology is probably of unprecedented proportions. And here the environmental contamination of children very likely ensures that the epidemic shall continue to reproduce itself in the generation ahead, as it apparently has from the generation preceding.

Reviewing the four zones observed in Figure 5, we can infer that certain turning points in the quality and weight of adult life conditions emerge along the status continuum represented in our expanded own-SES scale.

SUMMARY

In this sweep across the front defined by socioeconomic status with its multiform salients, we probed a number of discrete hypotheses with the following returns:

1. On the parental-SES range the frequency of impairment varies inversely and the Well rate varies directly.

2. This trend in Impaired-Well balance also characterizes those in the sample's youngest age group, who only recently have crossed the threshold from adolescence. It was thus possible to reject the hypothesis that SES-origin differentials in mental health had almost entirely been generated during adult life.

3. Among the several SES-origin groups no significant differences appear in the frequency of schizophrenic signs, anxiety-tension symptoms, or excessive intake behaviors. In all other pathognomonic dimensions covered, however, there is an *inverse* correlation with parental SES. These dimensions included disturbances in intellectual, affective, somatic, characterological, and interpersonal functioning.

4. Simultaneous analysis of age and status-origin against respondent mental health revealed that *both* demographic variables are related to mental health, each in its own right. This suggested first that parental-SES differences had implanted varying mental health potentialities among sample respondents during childhood; and second, that during the temporal course of adolescence and adulthood, precipitating factors had provoked overt morbidity among the more vulnerable people from all SES-origin strata. The combined power of these two demographic variables, as reflected in the index of Sick-Well magnitudes, is substantial.

5. The hypothesis was suggested that this triad of age, parental SES, and adult mental health was specific to the kinds of people who choose to live in an area like Midtown. That is, the identified nexus lacked wider currency in the American population. Evidence from three radically different populations indicated rejection of this hypothesis. Positively stated, the complex triad isolated in the Midtown sample may well characterize larger reaches of the American people.

6. Intergeneration status mobility, as read in a single point-of-time study, is a reciprocal factor relative to adult mental health. In the Midtown sample's coverage of three mobility types, the climbers had the smallest Sick-Well values and the descenders had the largest by far. For prospective longitudinal studies these data suggested the two-part hypothesis: (*a*) Preadult personality differences partially determine directions of status change in adulthood; (*b*) *on the whole,* upward status mobility is rewarding psychically as well as materially, whereas downward status mobility is depriving in both respects.

7. Reflecting the selective escalator effects of status mobility, own-SES shows an even stronger relationship to adult mental health than does respondent status origin.

8. Using four status indicators it is possible to divide the own-SES range into 12 finer strata. Revealed in these strata are four mental health zones, or contemporary worlds, seemingly marked at their boundaries by breakthrough points of differences in the size and security of economic underpinnings, in styles of life, in ego nurturance, and in their psycho-

social atmospheres. In zones C and D, at or near the poverty level, we discern particularly heavy pathogenic weights currently bearing on the especially vulnerable people.

For targeting of social policy, Midtown zones C and D, and likely their psychosocioeconomic counterparts elsewhere on the national scene, convey highest priority claims for milieu therapy in its broadest sense. Ultimately indicated here may be interventions into the downward spiral of compounded tragedy, wherein those handicapped in personality or social assets from childhood on are trapped as adults at or near the poverty level, there to find themselves enmeshed in a web of burdens that tend to precipitate (or intensify) mental and somatic morbidity; in turn, such precipitations propel the descent deeper into chronic, personality-crushing indigency. Here, we would suggest, is America's own displaced-persons problem.

For basic research, the joint evidence of this chapter and of several collateral studies of general populations here reviewed highlights the status system as an apparatus that differentially sows, reaps, sifts, and redistributes the community's crops of mental morbidity and of sound personalities.

In no way have we claimed that the mental health effects produced by this apparatus are determined by sociocultural processes alone. Nevertheless, in line with our field of professional competence and responsibility to future investigators, we have advanced a number of hypotheses that implicate certain specific forms of sociocultural processes operating within the framework of the social class system. These hypotheses focus on the four mental health zones we have found dividing Midtown's SES range. Distinguishing these zones, the hypotheses suggest, are economic factors linked to mechanisms of invidious discrimination that pervade the zones' respective way-of-life constellations. These postulates hold that toward one pole of the status range, in both preadult and adult life, such processes tend to penetrate the family unit with eugenic or prophylactic effects for personality development, whereas toward the opposite pole they more often work with pathogenic or precipitating effects.

These hypotheses chart paths of further necessary exploration. They can thereby lay reasonable claim to the attention of the several sciences that are joined in the "crash" research program of social psychiatry.

FOOTNOTES

[1] David E. Hailman, *The Prevalence of Illness among Male and Female Workers and Housewives*, Public Health Bulletin, 260, United States Public Health Service, 1941.

[2] L. G. Rowntree, K. H. McGill, and L. P. Hellman, "Mental and Personality Disorders in Selective Service Registrants," *J. Am. Med. Assoc.*, vol. 128, no. 15, pp. 1084–1087, Aug. 11, 1945.

[3] R. W. Hyde and L. V. Kingsley, "Studies in Medical Sociology: The Relation of

Mental Disorder to the Community Socioeconomic Level," *New Eng. J. Med.*, vol. 231, pp. 543–548, Oct. 19, 1944. Subjects were classified by place of residence, the residential unit being "the area under the jurisdiction of each local selection board." Each area was rated by criteria of "attractiveness as a residential section." The highest (A) of the six rating categories covered "wealthy suburban communities" and the lowest (F) covered "the worst Boston slums."

[4] Reported in *Chronic Illness in a Large City: The Baltimore Study*, 1957. The SES indicator employed was annual family income, as classified in four categories: Under $2,000, $2,000–$3,999, $4,000–$5,999, $6,000 and over.

[5] It should be observed that the four investigations had a second common characteristic; namely, psychiatric evaluation of the sample individuals was quite peripheral in emphasis to a physical examination. In the Boston Selective Service investigation, Hyde and Kingsley report that each psychiatrist examined about 50 men in a five-hour day, averaging in fact a few minutes per man. In the Baltimore study, a large number of chronic and acute somatic conditions were in the purview of the examining internists, who also made the psychiatric evaluation—if they were so inclined and scarce time permitted. Thus, the possibilities of judgmental error in the mental morbidity rates of all four studies loom large. Furthermore, when enmeshed in a variable like socioeconomic status, such an element of error can unwittingly work to bias the findings in various directions among different studies.

We can assume that reliability of mental health determination in a general population study partially depends on primacy of the psychiatric focus in the research design and also upon measures for controlling potential bias in the classification process.

[6] This hypothesis, it must be emphasized, cannot be tested in the patient aggregate counted by the Midtown Treatment Census nor in the patient aggregate enumerated by the earlier, parallel New Haven Psychiatric Census conducted by Hollingshead and Redlich. Both sets of patients are being held for later discussion of the treatment variable in the chapter that follows.

[7] To be sure, the trend in incapacitation rates—except between the extreme strata—is not altogether consistent. It should be remembered, however, that Midtown's mental hospital patients have been drawn principally from the incapacitated group. These patients were excluded from the Home Interview Survey but were included in the Midtown Treatment Census. In the latter operation, we could determine only own SES of patients, in a form allowing delineation of three status levels. As we shall see presently, the hospitalization rates in the upper, middle, and lower of these levels are 0.2, 0.4, and 0.7%, respectively. Accordingly, we can infer that if the hospitalized patients could be added to the several columns in Table 12-1, the trend in incapacitation rates on the SES-origin scale would probably be somewhat smoother and sharper than now appears to be the case.

In any event, the smaller the frequency values in a distribution, the more prone they are to magnify chance fluctuations due to sampling. Thus, with small frequencies some irregularity of trend is a negligible matter if the over-all direction of the trend is clear. Such a trend is discernible in the above incapacitation rates, especially when corrected for the hospitalized patients.

[8] Needless to say, this measure carries no claim to a place in the armamentarium of statistics. It is a supplementary reporting device for arithmetical summary of two rates and is employed for the convenience of the reader when intergroup comparisons of such paired rates become too complicated and cumbersome to juggle.

It will be recognized that the term "Sick" is paired with "Well" only as a short substitute designation for the sample's Impaired respondents.

[9] The intermediate (C and D) levels number 41% of the sample and account for 41 and 39% of the Well and Impaired categories, respectively.

[10] Thus, parenthetically, our findings do not rest entirely on the impairment band of the Study's mental health spectrum. The frequency of impairment usually varies in a counterpoise congruence with the Well category, in such a way that a generalization about one category often applies in reverse to the other. This seesaw bond seems to reinforce the apparent significance of both mental health types.

[11] The three classes are mergers of the six SES-origin strata and carry their original A to F notations. Only by such merger can the progressive shrinkage of cases in subgroups be partially compensated. The price paid, of course, is reduction in the range of SES differences.

[12] Of the four age groups in the sample it will be remembered that this is also by far the most favored in mental health composition (cf. Chap. 9).

[13] The five specific signs were: (1) I often have trouble in getting to sleep or staying asleep. (2) I am often bothered by nervousness. (3) I have periods of such great restlessness that I cannot sit long in a chair. (4) I am the worrying type. (5) I have personal worries that get me down physically.

[14] However, when respondents are classified according to own SES, the prevalence rates in the bottom and top strata are 7.4 and 1.8%, respectively, a difference that *is* statistically significant. Reflected thereby is the fact that in their own status these particular schizophrenics tend to be lower than their parents were.

[15] J. Ruesch, "Social Techniques, Social Status and Social Change," in C. Kluckhohn and H. A. Murray (eds.), *Personality in Nature, Society and Culture,* 1948, pp. 117–130.

[16] Among the 12 subgroups the only exception to this consistent trend is to be found on the 50 to 59 age level, where the respondents of middle-class origin stand at an Impaired-Well point somewhat below that of their upper-class neighbors. Beyond the possibilities of chance fluctuations, the explanation for this exception is not yet apparent.

[17] One possible accounting for this particular exception, beyond that of sampling variability, goes back to a problem sketched in Chap. 6. We there discussed the pressures of inadequate living and play space on Midtown families with young children and the consequent exodus of middle-class families (in particular) to city and suburban areas of less horizontal and vertical congestion. Accordingly, it seems possible that the age 30 to 39 parents of middle-class origin are a self-selected residue who have resisted these pressures bearing on the well-being of their children. If so, the question of why their age 40 to 49 SES-origin peers, with older children, do not reflect the same processes is one for which no immediate answer is at hand.

[18] This means, of course, that both of these factors must be controlled simultaneously, so far as possible, in analyzing the other sociocultural variables covered in the data chapters that follow.

[19] D. L. Farnsworth and H. K. Oliver, "Mental Health in College and University in the U.S. of America," *Intern. Social Sci. J.*, vol. 11, no. 1, p. 55, 1959. Also, D. L. Farnsworth, *Mental Health in College and University,* 1957, p. 112.

[20] S. Stouffer et al., *The American Soldier,* 1949, vol. II, Table 2, pp. 423–425.

[21] If the universe of white Army men in the enlisted ranks was more general than the Midtown universe in its national, rural-urban, and ethnic-origin dimensions, it was less general in age, sex, socioeconomic status and in screening out of grosser pathologies at the point of Selective Service examination.

[22] S. S. Bellin and R. H. Hardt "Marital Status and Mental Disorders among the Aged," *Am. Sociological Rev.*, vol. 23, no. 2, Table 4, p. 160, April, 1958.

[23] Based on interviewers' judgmental ratings. Although this departs from SES origin, particularly among the aged, we cannot assume its complete irrelevance to our present jigsaw interest in other community studies that have in any way explored the age, SES, and mental health triangle.

[24] Quoted by R. K. Merton, *Social Theory and Social Structure,* 1949, p. 132.

So ingrained is the emphasis upon status change in the *upward* direction that it can operate as a reflex in seemingly unrelated kinds of spatial situations. Referring to changes in tenancy, for example, a prominent New York realtor reports that in Manhattan "many tenants, commercial as well as residential, have a great reluctance to move down. When they move to new quarters, the space *must be* [italics added] on a higher floor than that which they leave" (*The New York Times,* Apr. 27, 1958). Because of street noises and lack of vistas, avoidance of quarters at low floors is of course utilitarian. However, this rationale is hardly involved in upward changes from quarters on the higher floors of Manhattan's skyscraper apartment houses and office buildings. The penthouse and the executive suite at the crown of the tower are

of course physical embodiments symbolizing Carnegie's phrase, "My place is at the top."

[25] S. M. Lipset and R. Bendix, *Social Mobility in Industrial Society,* 1959, pp. 65, 251.

[26] A. B. Hollingshead and F. C. Redlich, "Schizophrenia and Social Structure," *Am. J. Psychiat.*, vol. 110, no. 9, pp. 695–701, March, 1954.

[27] M. H. Lystad, "Social Mobility among Selected Groups of Schizophrenic Patients," *Am. Sociological Rev.*, vol. 22, no. 3, pp. 288–292, June, 1957.

[28] Lipset and Bendix, *op. cit.*, p. 65.

[29] *Ibid.*, pp. 251–252.

[30] E. Douvan and J. Adelson, "The Psychodynamics of Social Mobility in Adolescent Boys," *J. Abnormal and Social Psychol.*, vol. 56, no. 1, pp. 31–44, January, 1958.

[31] These hypotheses had been influenced by the promising conceptualizations of Ruesch bearing on (1) mobility motivations as emergents from "attitudes toward one's parents" and (2) the distinction between "climbers," and "strainers" as the upward aspiring who did not quite succeed. Ruesch, *op. cit.*, p. 125.

[32] Some writers, Ruesch included, tend to view the consequences of upward mobility in terms of stresses that we can subsume under the concept of role discontinuity. As employed in Chap. 9 above, this concept refers to the disjunctive predicament enveloping an individual when he acquires a rather new kind of role without adequate preparation of the requisite psychic defenses and social skills. This concept would probably apply in the main to the relatively rare instances of individuals who rise far economically in a relatively short period of time. However, our observations suggest that in most cases status mobility tendencies go back to the child's socialization in family, age-peer, and school settings. In such instances, furthermore, adolescence tends to be a period of informal apprenticeship in developing skills for the higher-status goal envisaged. Indeed, one of the major functions of high school and college life is to offer just such an apprenticeship. Thus, the usual gradual transition from parental SES to higher own status seems to us to be rather more continuous than discontinuous.

[33] Married women were excluded from this analysis because intergeneration status mobility was accomplished in their case through their choice of husband. The wife's effect on his status movement was expected to be secondary to his own personality determinants. Indeed, when we classify wives according to occupational differences between their father and their husband, we find relatively small variations in mental health composition among the three mobility types.

[34] The schizophrenic-process respondents form only a small fraction of the down-mobile group.

[35] Nine of the latter fathers were in the white-collar category and two in the executive-professional class. If the latter sons represent the extreme type of downward mobility, the six sons who rose from unskilled fathers to top-drawer careers exemplify maximal upward mobility. In this particular sample of American-born males such "rags-to-riches" movement occurred once in every 75 men. It is a plausible guess that the latter is an exceptionally high rate, probably to be found in few populations outside of New York City.

[36] In the case of married women, the indicators used were own education and husband's occupation.

[37] As evidence of one possible facet in this crisis potentiality, the history of collective pathology is not likely to minimize the significance of industrial Germany's Nazi period.

[38] It is not to be assumed that this group has been economically static. Reflecting not unionization but shortages in the local white-collar labor market, city-wide data on clerical office workers indicate that between 1949 and 1959 their salaries increased 59% in dollars and 21% in buying power.

[39] Applying as a criterion the frequency of *steady* employment during the minor economic recession of 1958, a national survey revealed a frequency of only 50% among workers with less than nine years schooling, 75% among high school graduates, and 90% among holders of a college degree. Unpublished study by the University of Michigan Survey Research Center and United States Census Bureau.

CHAPTER 13 *Socioeconomic Status Groups: Their Psychiatric Patients*

Leo Srole and Thomas Langner

In the Midtown sample of age 20 to 59 adults the over-all prevalence of mental morbidity is inversely related to the independent variable of parental socioeconomic status and related even more closely in this direction to the reciprocal variable of adults' present (own) SES.

We must turn now to another facet of the total complex, namely, how the frequency of psychiatric care varies with socioeconomic status. In this instance we shall apply own SES rather than SES origin as our test variable. We shall do so in part because the latter information is not available in certain segments of the treatment data gathered but principally because current status, if only in its economic aspects, is certainly the more relevant precondition of movement into prolonged professional care.

For present purposes we can first call upon the one-day prevalence data secured by our Treatment Census operation. The latter, it may be remembered, entailed the systematic effort to circumscribe the universe of Midtown residents, across the entire age range, who on May 1, 1953 were psychiatric patients in the care of public or private hospitals (institutionalized under five continuous years) or of out-patient clinics or office therapists. For reasons outlined in Chapter 11 (pages 204 to 205), the own-SES indicator we shall use in this particular analysis is a threefold classification of the housing quality observed at the last residence recorded for each patient.

Table 13-1 presents the one-day prevalence of Midtown patients in each status group (per 100,000 of its estimated population) as distributed through four kinds of psychiatric facilities together comprising the Total Patients rate.

Table 13-1. *Treatment Census* (Age Inclusive), Prevalence Rates (per 100,000 Corresponding Population) of Midtown Patients in Own-SES Strata by Treatment Site

Treatment site	Own SES (housing indicator)					
	Upper		Middle		Lower	
Hospitals:						
Public	98		383		646	
Private	104		39		18	
Combined in-patients		202		422		664
Clinics	61		160		218	
Office therapists*	1,440		596		178	
Combined out-patients		1,501		756		396
Total Patients rate		1,703		1,178		1,060
N = No. of patients§	(575)		(604)		(934)	

* These rates are uncorrected for the unreported patients of noncooperating office therapists. They are corrected for patients reported with addresses lacking or verifiably false.

Given the costs of private hospitals and office therapists there can be no surprise that the Midtown prevalence rates for these sites *decrease* downward on the socioeconomic scale, or that the patients in lower-cost public hospitals and clinics should *increase* downward on this SES scale.[1] As a result of these cross tendencies, at least in Midtown, Total Patients rate is largest at the top of the status range and smallest at the bottom.

The latter finding is in a direction quite the reverse of that observed in the previous chapter (Table 12-1), where mental impairment was seen to be least prevalent in the highest SES-origin stratum (A) and most concentrated in the lowest stratum (F). This is a paradox, seemingly, to which we shall return presently.

The SES trend in Table 13-1 is also in direct contradiction to that reported for the Psychiatric Census undertaken by the New Haven investigation. In their monograph, Hollingshead and Redlich[2] concluded that "the lower the [socioeconomic] class, the greater the proportion of psychiatric patients."

So striking a contrast warrants careful exploration. The New Haven authors record[3] Total Patient rate per 100,000 population in each of their several social class groups,[4] as follows:

New Haven SES Class	*Total Patients rate per 100,000*
I–II (highest)	556
III	538
IV	642
V (lowest)	1,659
All New Haven	798

This series of rates,[5] as published in the New Haven monograph, hardly represents the linear progression claimed in the conclusion just cited. Instead, it appears to conform more to a dichotomy in which class V for all practical purposes stands counterposed to the rest of the SES range.[6]

As for the seeming direction of the rate differences in the above series, two observations may be in order. First, the New Haven monograph estimates that approximately 40 to 50 office patients were not reported by therapists, principally New York practitioners, who refused to cooperate[7] with the study. These commuting, Connecticut patients of New York City psychiatrists were not included in the above New Haven rates. However, it seems most likely that such shielded patients were predominantly from New Haven's highest social class levels. If so, they represent a pinpointed error of understatement, one that by our estimate could conceivably raise New Haven's combined class I–II patient rate[8] from 556, as reported, toward 700.

Several pertinent reservations also attach themselves to New Haven's class V patient count. Included in this enumeration were transients committed to a state hospital by New Haven police with key information about their home community undeterminable.[9] Not revealed is the number of such rootless transients charged to New Haven's count as class V. Moreover, the sample of New Haven's general population, drawn to estimate the city's inclusive social class distribution (for service as denominators in calculating rates per 100,000 population), explicitly excluded *all* transients.[10]

Second, the New Haven investigators make this observation: "Once a class V person is committed to a mental institution, the likelihood of his return to the family is small."[11] In terms of our present concern, this would seem to imply that the exceptionally high prevalence rate of New Haven's class V is in part a result of the cumulative pile-up of its unmoving sick as the more or less permanent "slag heap" deposit of custodial patients in public hospitals. To probe this inference we would need a New Haven counterpart of our Table 13-1 above. This has not been published, but for such a purpose it is possible to regroup several New Haven tabulations[12] and convert their percentages into patients per 100,000 estimated population in each of the social class groups. These are presented in Table 13-2.

Inspection of Table 13-2 frequencies reveals the same SES trends in New Haven as were observed for like treatment sites in Midtown (Table 13-1). That is, patient rates for the low-cost facilities (public hospitals and clinics) *increase* downward on the socioeconomic scale, whereas for the high-cost services (private hospitals and office therapists) the trend is for the patient frequencies to *diminish* with descending SES. The parallel Midtown and New Haven evidence on these counter trends suggest anew

Table 13-2. New Haven Psychiatric Census (Age Inclusive), Prevalence Rates* (per 100,000 Corresponding Population) of New Haven Patients in Own Social Class Groups by Treatment Site

Treatment site	Social class group			
	I–II	III	IV	V
Hospitals:				
Public	89	242	464	1,500
Private	85	17	6	—
Combined in-patients	174	259	470	1,500
Clinics	30	66	53	115
Office therapists	352	213	119	44
Combined out-patients	382	279	172	159
Total Patients rate	556	538	642	1,659
N = No. of patients	(150)	(260)	(758)	(723)

* Adapted from A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness*, pp. 265, 419. Source data are used by permission of John Wiley & Sons, Inc., New York.

that if the inescapable calculus of cost relative to financial means is not the only factor determining whether and where psychiatric care is sought and secured, it probably is one of the most important.

A closer comparison is warranted of New Haven's classes V and IV in Table 13-2. These two groups do not differ in either private hospital rate or combined out-patient frequency. However, they *do* diverge in their public hospital rates by a decisive margin of 3.2:1.

Noteworthy in the comparison next of the public hospital frequencies in Tables 13-1 and 13-2 is the general *numeric* similarity of these rates between the Midtown pair of upper and middle strata on the one hand and the New Haven series of classes I–II, III, and IV on the other. Residually highlighted thereby is the sharp contrast differentiating the public hospital rate in the bottom stratum of the two communities, i.e., 646 for Midtown's lower SES group and 1,500 for New Haven's class V.

If the "permanently" hospitalized (by our definition those confined continuously for five years or more) are predominantly drawn from the lowest socioeconomic level, then the pinpointed intercommunity contrast just mentioned is in part a consequence of the facts that (1) in its patient prevalence count one investigation (New Haven) included these piled-up people in limbo and (2) the other (Midtown) excluded them on grounds that they could no longer be meaningfully considered bona fide residents of the community.

On two lines of analysis, accordingly, the extraordinarily high public hospital rate of New Haven's class V appears to be a function, at least in

part, of the accumulation and stagnation in state hospitals of the terminally confined, who mainly originate in this group.

If class V has the standout Total Patients rate (1,659) of all SES groups in New Haven, in Midtown this distinction belongs to the top stratum (rate: 1,703) at the opposite end of the socioeconomic hierarchy. Table 13-1 tells us that accounting for seven-eighths of this peak frequency are the patients reported by Manhattan office therapists,[13] who by a 4.4:1 margin outnumber (per 100,000 local population) their fellow professionals in New Haven. Office patients all told represent nearly half of Midtown's inclusive patient universe reported to us, and by their numbers they have imposed their skewed SES composition on the trend in Total Patients rates among Midtown's several SES groups.

On the other hand, with New Haven's office therapy cases numbering only about 20% of all local patients, Total Patients rates in that community are dominated to a greater degree by the public hospital occupants and *their* particular kind of skewed SES make-up.

In Chapter 8 we offered the seemingly obvious but often overlooked point that intercommunity variations in the treatment capacities of their psychiatric facilities place different ceiling limits on their patient rates, thereby tending to conceal any real differences in their over-all prevalence of mental illness.

This can now be given the obvious amplification that intercommunity variations in the development of high-cost and low-cost psychiatric facilities will inevitably place differential ceilings on the number of people in like-SES groups who can get psychiatric care. All in all, it is difficult to avoid the conclusion that divergences in Total Patients rates among a community's several socioeconomic groups have a significance decidedly less etiological than that seemingly held out to them at some points in the New Haven monograph's earlier chapters.

The issue of ambulatory versus hospital sites of treatment, earlier discussed, becomes programmatically sharpened when narrowed down to the psychotic patients uncovered by our Treatment Census. In Table 13-3 we present Midtown's psychotic patients in each status group as they divide on the ambulatory-hospital line of psychiatric facilities.

Table 13-3. *Treatment Census* (Age Inclusive), Distribution of Midtown's Psychotic Patients in Own-SES Strata by Treatment Sites

Treatment sites	Own SES		
	Upper	Middle	Lower
Out-patient	49.6%	25.2%	10.0%
In-patient	50.4	74.8	90.0
N = 100%	(113)	(274)	(598)

As expected, of course, Midtown's large out-patient facilities, or more particularly its corps of office therapists, operate to the far greater service advantage of the high-status psychotic needing treatment than to fellow psychotics on SES levels below him. Suggested thereby is the urgent importance of low-cost out-patient clinics and day-care, night-care, and home treatment facilities to correct this service imbalance among the more seriously sick in the community.

PSYCHIATRIC ATTENTION AMONG THE HOME SURVEY'S IMPAIRED RESPONDENTS

In the preceding section, patient rates yielded by our Treatment Census were calculated relative to the total number of Midtown people comprising each status group. If all the ill came under treatment, as generally happens with a dread infection like polio, such rates could stand for the frequency that a disease occurs in a given group per 100,000 of its total population. With mental pathology, however, we have every reason to believe that the treated represent merely a fraction of all the sick, whose numbers are generally unknown. Under this circumstance, the count of patient numbers is the product of at least two unknowns: (1) the *over-all* frequency of the disorder and (2) the extent to which the sick manage to get psychiatric care.

However, the count of patient numbers can break out of its besetting clouds of ambiguity if it is converted into a rate per 100 in presumptive need of professional help. Such a rate acquires significance by giving at least some rough inkling of the number and character of the help-needy who get professional attention as compared with those who go unattended. The unmet needs so uncovered, if sizable in extent, would be an action challenge to both the healing professions and the community they serve.

In view of the specific mission assigned to the Midtown Treatment Census operation, it was felt that the treatment factor could be given only a brief glance during Home Survey interviews with a representative sample of Midtown adults. Given the hard-won wisdom of hindsight, we concede this short cut to have been an error.

In any event, every respondent in the Home Survey sample was asked whether he had ever gone to a psychiatrist or a nerve specialist.[14] Affirming respondents were then asked only one other question, namely, when the therapist was last seen.

Such affirming respondents were subsequently pressed into service as the Home Survey's particular criterion of a patient, under a definition considerably wider than that applied in our Treatment Census operation. Those counted by the latter's methods had been admitted into a program of psychiatric care, however diverse or brief may have been the treatment content. However, by the Home Survey's broad-spectrum definition,

patients included not only respondents who had received intensive treatment, but also those who in seeing a psychotherapist had not progressed beyond (1) a consultation, (2) one or more diagnostic sessions, or (3) unsuccessful application for treatment. Instances such as these three indicate the Home Survey's criterion of a patient to be a respondent who, however briefly, secured and directed the attention of a psychotherapist to his felt need for help. This liberal definition should be taken into account as we extract the patient-history variable from the Home Survey sample. We divide respondents into three categories: (1) current patients, ambulatory of course, who had last seen the therapist during the thirty-day period preceding the interview; (2) ex-patients, covering all others who had been in either a hospital or an ambulatory service; and (3) never-patients.

We now seek the connection between this patient-history variable and socioeconomic status, not on the broad base of the inclusive community population (as in Table 13-1), but only among Midtown adults who are in a mental condition of probable help-need, at the very least for professional consultation, diagnosis, or prophylaxis. These we find represented by the Home Survey's 389 (age 20 to 59) sample respondents who were judged by the Study psychiatrists to be in the Impaired category of the mental health classification scheme. In Table 13-4 the own-SES yardstick is a composite derived from scored rankings of respondents' education, occupation, income, and rent. However, given the relatively small number of Impaired people, the six A to F strata used in the previous chapter must be merged into three.[15]

Table 13-4. *Home Survey Sample* (Age 20–59), Distributions of Impaired Category Respondents in Midtown Own-SES Groups by Patient-History Classification

	Own SES (four indicators)		
	Upper (A–B)	Middle (C–D)	Lower (E–F)
Current patients (ambulatory)	19.1%	4.5%	1.1%
Ex-patients (ambulatory or hospital)	32.4	18.0	19.9
Ever-patients	51.5	22.5	21.0
Never-patients	48.5	77.5	79.0
N = 100%	(68)	(134)	(187)

Relative to the lower stratum's Impaired people, the current patient rate in the middle and upper group is greater by 4 and 18 times, respectively. This trend in the probable "at need" segment of the general population reveals more clearly than before the highly selective nature of the current patient traffic to the doors of the ambulatory facilities.

The ex-patients, on the other hand, are more heterogeneous in terms of service site, including as they do the patrons of both ambulatory facilities

and hospitals. From clues provided by our Treatment Census data, we estimate that these ex-patients were divided between hospital and ambulatory sites roughly as follows on the own-SES range:

	Upper	Middle	Lower
Ex-patients:			
Hospital	4.4%	6.0%	12.3%
Ambulatory	28.0	12.0	7.6
Total ex-patients of Impaired group	32.4%	18.0%	19.9%

Thus, within the circumscribed confines of the Impaired category of respondents, almost half (47.1%)[16] of those belonging in the upper-SES stratum are estimated to be ambulatory ever-patients, as compared with one-sixth (16.5%) and one-twelfth (8.7%) of the middle and lower SES, respectively.

We can now confront the seeming paradox, posed by Tables 12-1 and 13-1, where on the one hand over-all prevalence of mental morbidity was seen to *expand* downward on the SES pyramid and, on the other, treatment rates (per 100,000 total population) tended to *shrink* with descending socioeconomic status. From the previous paragraph it becomes apparent that if the top SES stratum has the fewest cases of mental morbidity, these cases present an even chance of sooner or later seeking ambulatory psychiatric service. The lower status group, on the contrary, has by far the largest prevalence of Impaired respondents, but the latter have only a slight chance (1 in 12) of ever coming to the professional attention of an out-patient facility. As net effect, into the traffic going through the community's psychiatric services the inclusive upper stratum, although healthier on the whole, pours more patients, relative to its numbers, than does the most impairment-laden bottom SES group. Once again, therefore, we have the suggestion that group-to-group differences in prevalence of psychiatric care or attention (Tables 13-1 and 13-4) can be completely misleading as a measure of intergroup variations in the over-all prevalence of mental morbidity.

HELP-NEED AND PROFESSIONAL ORIENTATION

In what remains a significant opening discussion of the matter, the New Haven investigators[17] have extracted this important point from observations on 50 intensively studied psychiatric patients: beyond the play of economic factors, there are SES-linked divergences in orientation to psychiatry that may partially explain the varying patient rates of the several social class groups. We did not attempt to retrace their pioneering steps in this direction. However, in our Home Survey sample we did ex-

plore respondents' readiness to advise, and presumably to accept, several relevant forms of professional help in instances of behavioral disturbance. By their replies, all sample respondents have been placed in one of these four professional orientation categories: (1) those advising a psychiatrist, a psychologist, or an institutional equivalent; (2) those others recommending a physician or an institutional equivalent; (3) those remaining who would call upon a member of some other remedial profession, e.g., social worker or clergyman; (4) the residue, who made no reference to professional intervention of any kind.

Table 13-5. *Home Survey Sample* (Age 20–59), Distributions of Midtown Sample Respondents in Own-SES Strata by Professional Orientation

Respondent recommendation	Own SES		
	Upper (A–B)	Middle (C–D)	Lower (E–F)
Psychotherapist	51.2%	26.4%	12.3%
Physician	11.8	11.2	12.3
Other professional	6.3	10.4	12.3
No professional	30.7	52.0	63.1
N = 100%	(560)	(556)	(544)

Of course, readiness of the help-needy person to accept professional service is only one element in the highly complicated total situation that determines what, if any, steps he takes to get help. Another element is the prevailing view or attitude climate that his group tends to press upon him and his family toward taking a certain course of action. From Table 13-5 we can surmise that the Impaired never-patient of the upper-SES bracket would find a majority of his status peers urging him to see a psychiatrist. If he is of middle or lower status the predominant tendency of his peers would apparently be in a direction other than advising professional assistance. However, compared to the lower-SES stratum a substantially bigger minority of the middle-class group would suggest a psychotherapist, namely, 12.3 and 26.4%, respectively. These data from a large sample of community residents may supplement the New Haven observations on a small sample of psychiatric patients. Seemingly implied is that SES-linked attitude climates operate differentially to facilitate or complicate the path a help-needy person must take if he is to find his way into a patient-therapist relationship.

OUTCOME OF EXPOSING IMPAIRMENT CASES TO PSYCHIATRIC ATTENTION

Our final question poses this issue: For those who do get psychiatric attention, what SES-mediated effects differentially accrue to patients

from exposure to a therapist in a service setting? This is an exceedingly difficult empirical question—one not remotely contemplated when we designed the Home Survey operation. Nevertheless, a suggestive clue may emerge from the circumstance that this survey encountered 182 sample respondents who, by the criteria of our patient-history classification, are ex-patients. In the interest of expanding on this clue, let us assume that the reported relationship with a therapist probably would not have been arranged by, or for, these respondents unless a condition of Impaired mental health was present or imminent.

If this assumption is correct, and we have nothing to support it except plausibility, then we can take note that of these 182 ex-patients 83 are currently still in an Impaired state of mental health, whereas 99 are now functioning more or less adequately despite symptoms of underlying pathology. Of considerable interest at this point are the following differences among the ex-patients when sorted by their own-SES level:

1. Of 78 upper-SES ex-patients, the non-Impaired number 71.8% (the Impaired, 28.2%).
2. Of 50 middle-SES ex-patients, the non-Impaired number 52% (the Impaired, 48%).
3. Of 54 lower-SES ex-patients, the non-Impaired number 31.5% (the Impaired, 28.2%).

The potential clue buried in these data may be stated as follows: Within the universe of patient-therapist relationships, the chances of a successful outcome (as judged by the operational criterion of reversal from a state of Impaired to a state of non-Impaired mental health) seem to vary considerably among the several socioeconomic segments of the patient population, in a range from about 7 in 10 of the top segment to 3 in 10 of the bottom one.

If this clue should prove to be substantive, a number of factors could be adduced to explain the outcome differences. In fact, some of these variables have already been insightfully discussed in parts 4 and 5 of the New Haven monograph. Here we would only add our view that if the American patterning of socioeconomic status performs central social system functions, it also has serious dysfunctional aspects that remain a problem to its powers of self-correction. The unequal consequences of these aspects for the development of mental health were discernible in the preceding chapter. Here we have presented clues and evidence attesting to one specific dysfunction in the social order: the conflict between the status system as it actually operates and a bedrock value on which the healing professions are founded, namely, that the sick shall have access to the ministrations of the profession irrespective of their social differences.

SUMMARY

In the previous chapter our efforts were directed toward uncovering the lines of association between group mental health composition and socioeconomic status in several of its major aspects. Our point of focus in this chapter has been narrower, namely, the connection between psychiatric attention or care and adults' present (own) SES. On this level, the earlier New Haven Psychiatric Census study has made possible some illuminating intercommunity comparisons. However, our own sightings on this nexus have come from the twin vantage points provided by our Treatment Census and Home Survey operations.

Comparison of the Midtown and New Haven patient rates indicated like SES trends for like treatment sites. Notwithstanding this parallelism, the anomaly emerged that the SES trend in Total Patients rates of the two communities seemed to move in opposite directions.

Analysis suggested first that New Haven's inverse trend was beset on the one hand with some technical artifacts and, on the other, with a special tendency of the lowest (V) stratum's public hospital patients to become permanently institutionalized. In Midtown the opposite SES trend was shown to be a consequence of the numerical dominance of office therapy patients in this universe of patients and the overshadowing impact of their high socioeconomic status on the SES differences in Total Patients rates.

Thus, the relative development of high-cost and lost-cost facilities in a community's treatment apparatus will variously affect people at different SES levels in their chances of securing psychiatric care.

Opposite SES trends were also encountered in comparing the Midtown Study's two field operations. The Home Survey revealed that over-all prevalence of mental morbidity varied inversely with socioeconomic status. On the other hand, the Treatment Census reported Total Patients rates rising between the lower and upper socioeconomic strata. Using a broader definition of patient history as its criterion of psychiatric attention, the Home Survey Impaired respondents who satisfied this definition also showed the latter kind of SES trend. Integrating these separate findings, we observed that as we descend the continuum of socioeconomic status, Midtown's Treatment Census rates represent progressively smaller fractions of progressively larger reservoirs of mental morbidity.

In comprehensive terms, compared to the "affluent" group the "poor" have many more mentally impaired people; their help-needy people far less often get psychiatric attention; and when their impaired members do get such attention, the outcome, to judge from an elicited clue, rather less often appears to be a significant and sustained gain.

Indicated were the implications of sociological dysfunctions to be drawn from the large picture sketched in this and the preceding chapter.

FOOTNOTES

[1] This SES trend of patient rates in publicly supported mental hospitals has been reported in other studies of patients, usually of the first-admission (incidence) category. Cf. A. J. Jaffe and E. Shanas, "Economic Differentials in the Probability of Insanity," *Am. J. Sociol.*, vol. 44, pp. 534–539, January, 1935; R. E. L. Faris and H. W. Dunham, *Mental Disorders in Urban Areas*, 1939; C. W. Schroeder, "Mental Disorders in Cities," *Am. J. Sociol.*, vol. 48, pp. 40–48, July, 1942; R. E. Clark, "Psychoses, Income and Occupational Prestige," *Am. J. Sociol.*, vol. 54, pp. 433–440, March, 1949; R. M. Frumkin, "Occupation and Major Mental Disorders," in A. M. Rose (ed.), *Mental Health and Mental Disorders*, 1955, pp. 136–160; B. Malzberg, "Mental Disease in Relation to Economic Status," *J. Nervous Mental Disease*, vol. 123, pp. 257–261, March, 1956; and B. Kaplan, R. B. Reed, and W. Richardson, "A Comparison of the Incidence of Hospitalized and Non-hospitalized Cases of Psychoses in Two Communities," *Am. Sociological Rev.*, vol. 21, pp. 572–79, August, 1956. However, the trend was not found, at least for first-hospital-admission schizophrenics, in the study reported by J. A. Clausen and M. L. Kohn, "Relation of Schizophrenia to the Social Structure of a Small City," in B. Pasamanick (ed.), *Epidemiology of Mental Disorder*, 1959, pp. 69–86.

[2] A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness*, 1958, p. 207.

[3] *Ibid.*, p. 210.

[4] These groups were based on scored, differentially weighted rankings of education, occupation, and area of residence. Partly because institutional files were found to be markedly irregular in recording occupation and schooling, the Midtown Treatment Census has used only quality of residence as its indicator of patients' SES. Despite this difference and differences in dividing the socioeconomic range of the two patient populations, the Midtown and New Haven sets of data lend themselves to critical comparison of their SES trends.

[5] When we undertake computations for classes I and II separately, the rates we secure are 267 and 668, respectively, based on data (p. 199) in the New Haven monograph.

[6] From notes taken of Redlich's report ("Social Class and Psychiatry," p. 181) given at the New York Academy of Medicine, Mar. 9, 1955, it seems clear that he himself viewed the New Haven social class rates, group V excepted, as essentially describing a plateau.

[7] Hollingshead and Redlich, *op. cit.*, pp. 22–24.

[8] See also S. W. Ginsburg's review, *Am. J. Orthopsychiat.*, vol. 29, no. 1, p. 195, January, 1959.

[9] Hollingshead and Redlich, *op. cit.*, p. 19.

[10] A. B. Hollingshead and F. C. Redlich, "Social Stratification and Psychiatric Disorders," *Am. Sociological Rev.*, vol. 18, no. 2, p. 167, April, 1953.

[11] Hollingshead and Redlich, *Social Class and Mental Illness*, 1958, p. 343.

[12] *Ibid.*, pp. 265 and 419.

[13] In Chap. 11 (p. 204) we indicated that information on 19% of the Midtown office patients reported to us failed to include the requested home address information needed to classify housing quality as a socioeconomic indicator. To prevent their exclusion from the rates in Table 13-1, we arbitrarily assumed they were distributed on the present SES trichotomy as were the 81% of reported office patients for whom correct addresses were furnished. However, it seems plausible that office therapists would be more prone to shield the addresses of "top-drawer" people than of others. If so, the indicated correction we have introduced for the address-missing patients would

make the office therapy rate of the Midtown upper-SES group an *understatement* of the true rate.

It is impossible to estimate the number of patients altogether unreported by the Manhattan office therapists. If these patients also are predominantly from the top rung of the socioeconomic ladder, then they represent a further error of understatement attached, with magnitude unknown, to the upper-SES rate in Table 13-1.

[14] The respondent was credited with a "yes" if he answered "no" but volunteered that he had been to a clinical psychologist or some other kind of certified therapist.

[15] Such merger of course tends to reduce differences between groups at the extremes of the SES range.

[16] This proportion is derived by adding the 28.0% of ambulatory ex-patients indicated to the 19.1% of ambulatory current patients reported in Table 13-4.

[17] Hollingshead and Redlich, *Social Class and Mental Illness*, 1958, pp. 335–356.

CHAPTER 14 *Generation-in-U.S. and Rural-Urban Origin*

Leo Srole and Thomas Langner

American history is the epic of a nation hewed out of wilderness by the brawn and wits of diverse peoples gathered from the length and breadth of the Old World. Nationality and religious segments in this patchwork diversity are being held for separate examination in the two chapters that follow.

Here we want to look at the demographic architecture of the Midtown population from another angle, one that delineates a tier of groups arranged in a sequence of generations from the immigrants through successive orders of their lineal descendants. In the foundation group, of course, are all the foreign-born, designated generation I. American-born offspring of immigrants stand as generation II, their grandchildren as generation III.[1] Midtowners who have four American-born grandparents are placed in generation IV; that is, the nearest immigrant forebears were great-grandparents or even more remote ancestors.[2] It is no surprise, therefore, that this oldest-in-U.S. generation group is largely derived from Old American, Anglo-Saxon stock.

On this ordering of the generations, the Midtown age 20 to 59 sample adults are distributed[3] as follows:

Generation	*Per cent*
I	35.7
II	34.5
III	15.9
IV	13.6
Unknown[4]	0.2
N = 1,660	99.9%

What specific relevance to the concerns of the Midtown Study has the seeming genealogical criterion that differentiates these generation levels? In the first place, these are not categories that claim only conceptual identifiability. Rather, they are in varying respects groups that have

separate identities and self-images. Certainly, immigrants—within the several nationality divisions—have their own informal associations and accessible formal organizations. So also does the Old American generation IV, as can be seen in the Colonial Dames of America, the Sons of the American Revolution, and the Society of Colonial Wars, among others.

Lerner[5] refers to the persistent effort during the colonial period "to build an aristocracy of prior immigration." Every wave of immigrants from the early English colonists onward tended to look askance on subsequent newcomers as somehow of suspect and inferior character. The invidious implications of the current self-styled "patriotic societies" within the Old American group are not likely to be missed by those who are excluded on ancestral criteria. Of course, more than mere implication was involved in the congressional acts of 1921 and 1924 which drastically cut the number of newcomers, above all by discriminating against the more recent sources of immigration.

As subsequent professional analyses of school textbooks in American history have shown, the facts about immigrants reported there often "were, to put it politely, uncivic, uncivil, and untrue."[6] Saveth, one of these analysts, refers to such textbooks as "miseducation by insult, whereby American children are systematically exposed to a racist evaluation of—in so many cases—their own parents and grandparents."[7]

Such grading of the generations on an inferior-superior scale was one process among others serving to deepen the boundaries between these groups.

THE GENERATION-IN-U.S. HYPOTHESES

Even more important for our research concerns was a chain of other processes that hinge on these facts: Generation IV, in personality and behavior, is "at home" under the roof of American society, where this group is implicitly invested with the role of host to others and model for the indigenous way of life. By contrast, immigrants on arrival are often at the farthest pole removed as strangers in the land and aliens to the patterns and nuances of American conduct. During his remaining lifetime the immigrant proceeds some distance in acculturation toward the American model; his children proceed considerably farther, and in his adult grandchildren the process is substantially completed.

An extensive literature on the experiences accompanying this process has accumulated in the work of novelists, sociologists, and a new generation of historians. Almost without exception they portray the immigrant as one caught in the torturing dilemma of the iron maiden type, impaled by himself when he yielded to irresistible environmental pressures on issues of central importance to his integrity and impaled by

the environment when he immovably refused to yield to these pressures under the interdictions of his "out of context" personality.

Rarely has this predicament been conveyed with more detailed insight than in Handlin's *The Uprooted*.[8] On the impact of transplantation, Handlin notes that the "shock and the effects of shock, persisted for many years." [9] Among these effects,[10]

> . . . the immigrants witnessed in themselves a deterioration . . . a marked personal decline and a noticeable wavering of standards. [They] found it difficult, on the basis of past habits, to determine what their own roles should be . . . they had been projected into a situation where every element conspired to force them into deviations. . . . It was significant of such deviations —pauperism, insanity, intemperance, gambling—that they represented a yielding to the disorganizing pressure of the environment. . . . If only a small number actually plunged into [such deviations] many more lived long on the verge.

In short, here was the discontinuity phenomenon, not in one role but in the immigrant's entire complex of roles—as worker, consumer, tenant, neighbor, husband, father, et al. In the light of these multiple points of potential stress, it was hypothesized that on the generation scale mental health conditions would be found most adverse of all in the Midtown immigrant group.

The predicament of the generation II child, although different, was directly chained to that of his parents. The latter saw themselves challenged and disarmed on almost every front of their new lives. However, one salient on which they could defend themselves was in the refuge of their dwelling, where they partially recreated a family regimen rooted in their traditions, perhaps now magnified and idealized.

This was the intrafamily atmosphere in which they often raised their child without serious extrafamily challenges during his preschool years. Thereafter, however, he came under the increasing pressures of peers and school to conform with American ways. Between these crosscurrents of conflicting sets of values and behavior patterns, both of which exerted powerful claims upon his identifications and loyalties, the generation II child was caught.[11] It has been said of this generation that it is their predicament to stand in both cultural worlds but to be completely at home in neither. Complicating the situation further was the unmistakable antiforeigner bias that these children encountered among people perceived as the authentic American type, including the writers of textbooks in American history. Internalizing this attitude led them to rebel with focused hostility against their immigrant parents, seen miscast as incongruous models and overbearing authorities. In culmination, they could reject themselves as well in a form that Lewin[12] has called "self-hatred." To apply a currently popular phrase, they were the apparent prototypes of an "angry generation."

Hypothesizing about generation II adults, on these grounds, we could expect to find their mental health composition tending in a relatively unfavorable direction. However, we also anticipated that it would be less adverse than that of generation I. Our reasoning was twofold: (1) In degrees of discontinuity there was greater disparity for the immigrant between his natal home and the new environment than there was for the generation II individual; (2) in the intergeneration conflict the American environment was openly a supportive ally of the child and an antagonist of his immigrant parent. This would intrinsically tend to tip the balance, in settling the conflict, toward the former and away from the latter. Thus, the blows of the encounter, we observed, were harder on the foreign-born parent than on his American-born child.

In framing predictions for generation III we had in mind the notable essay by historian Marcus Hansen.[13] Contrasting the second generation's conflicted rejection of the parents' traditional way of life, Hansen says of the third generation: "It has none of the bitterness or heartbreaking features of its predecessors. . . . Whenever any immigrant group reaches the third-generation stage of development a spontaneous and almost irresistible impulse arises which forces the thoughts of many people of different professions, different positions in life, and different points of view to interest themselves in that one factor which they have in common: heritage. . . ."

This statement was congruent with our own wide but unsystematic observations that, not being defensive either about their American identification or about their family tradition, generation III children are no longer conflicted in these important dimensions of the self-image. To this extent we could hypothesize that in adulthood they would appear as a group less vulnerable to the blows of life and more skilled in crisis management than would generation II.

Compared to generation IV, in turn, the only situational liability we could discern for generation III during childhood was their generation II parentage and the latter's own embattled personality development. Accordingly, it seemed plausible to advance the consistent general hypothesis that progressively upward on the generation scale, i.e., from I to IV, the group mental health trend would be toward diminishing frequencies of mental pathology.

HOME SURVEY SAMPLE: MENTAL HEALTH DISTRIBUTIONS

Our hypothesis that mental health varies inversely with generation-in-U.S. will here be tested for the first time on a community cross-section population. Also for the first time, the generation variable will be refined to go beyond the usual simple dichotomy (foreign versus American birth) to encompass three categories of the native-born.

We turn now to Table 14-1 for distributions of the four Midtown generation groups on the psychiatrists' classification of mental health.

Table 14-1. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Generation-in-U.S.

Mental health categories	Generation groups			
	I	II	III	IV
Well	16.1%	17.8%	17.4%	27.9%
Mild symptom formation	36.0	37.8	36.7	32.3
Moderate symptom formation	21.2	21.5	23.9	22.6
Impaired	26.7	22.9	22.0	17.2
Marked symptom formation	14.9	13.6	11.8	8.8
Severe symptom formation	9.4	6.3	7.2	5.8
Incapacitated	2.4	3.0	3.0	2.6
N = 100%*	(593)	(573)	(264)	(226)
Sick-Well ratio	165	128	126	62

* Four respondents are of unknown generation.

Focusing first on the two intermediate mental health categories, i.e., Mild and Moderate symptom formation, we note, as in previous chapters, high consistency of their rates across the generation range. Looking next to Well and Impaired frequencies, we see that generations II and III are identical; relative to these, generation I has a somewhat larger Sick-Well ratio and generation IV a decidedly smaller Sick-Well ratio. As cumulative effect, the Well and Impaired frequencies of the immigrants (16.1 and 26.7%, respectively) are completely reversed in the fourth-generation group (27.9 and 17.2%, respectively).

Except that the anticipated difference between generations II and III does not appear, the Sick-Well ratios vary in the direction postulated, although hardly to the degree that had been expected. Moreover, before this modest support can be claimed for the hypothesis as tested, we must take the precaution of inquiring about the potential play of other demographic factors.

This inquiry becomes particularly pertinent when we discover age differences among the sample's generation groups.[14] Likewise, there are some marked differences in SES origin. As we have seen in the previous chapter, frequency of impairment varies directly with respondent age and inversely with SES origin. Accordingly, we must analytically parcel out the separate effects of the latter two factors if we are to determine what residual relation remains between the generation variable, in its own right, and mental health. This can be accomplished most expeditiously by the device of "standardizing" the generation groups'

populations. By this method, we recompute the mental health distributions that would result if all four groups were identical in age and SES origin with a population accepted as the standard.[15]

Table 14-2. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Generation-in-U.S. Groups as Standardized for Age and Parental SES

Mental health categories	Standardized generation groups			
	I	II	III	IV
Well	16.5%	18.1%	16.6%	24.3%
Mild symptom formation	36.5	37.9	36.8	26.4
Moderate symptom formation	21.7	21.0	23.9	26.3
Impaired	25.3	23.0	22.7	23.0
N = 100%	(593)	(573)	(264)	(226)

On this standardized basis, the mental health distributions in the several generation groups appear as presented in Table 14-2. The limited support for our test hypothesis, as read from Table 14-1, is here seen to be largely spurious.[16] For all practical purposes, no relation between generation and mental health remains[17] when SES origin and respondent age are held constant.[18] This says, in effect, that there are no mental health divergences among respondents of different generation levels who are alike in parental SES and age. To be sure, the latter variables in combination are highly correlated with respondent mental health. And it may be expecting too much of a third demographic variable to come through the fine screen of these two with a separate relationship all its own. Yet, in the light of the general evidence that prompted our hypotheses about the four generation groups, this is exactly what we *did* expect. In failing this expectation, the findings of Table 14-2 seemed to flatly contradict the nearly unanimous testimony of a large and diverse corps of competent observers. Accordingly, we regarded our data with special skepticism and proceeded to probe and dissect them from a number of possible angles.

DATA AND HYPOTHESES RECONSIDERED

There was the obvious possibility, for example, that the Study psychiatrists had been influenced by their own observations of the conflicted predicaments in which both immigrants and their children were caught. If so, in classifying respondents' mental health they could have regarded a given set of symptoms more seriously if occurring in generation III or IV individuals than if found in generation I or II people. In that event,

of course, real differences among these groups could be more or less leveled out. However, inspection of the psychiatrists' Rating I classifications, made without knowledge of respondents' generation level, indicated trends in no way different from those reported in Table 14-1. Thereby, the possibility that a judgmental bias intruded at the point of classifying mental health can be confidently rejected.

A second possibility was that the evidence prompting our hypothesis was biased in the sense that it overstated the negative aspects of the immigrant's situation and understated the positive aspects. Lerner seems to imply this view:[19]

> The immigrant experience was . . . somber and tragic. Yet it would be a mistake to see it thus without adding that it was also one of excitement and ferment. Millions of the immigrants, after giving their strength to the new country, died with a sense of failure and frustration. But many more millions survived their ordeal, became men of influence in their communities, and lived to see the fulfillment of the American promise in their own lives doubly fulfilled in the lives of their children. "Everything tends to regenerate them," De Crevecoeur wrote of his fellow immigrants, "new laws, a new mode of living, a new social system; here they are become men: in Europe . . . they withered and were mowed down by want, hunger and war; but now by the power of transplantation, like all other plants, they have taken root and flourished!" One doubts whether this lyric description, written at the end of the eighteenth century, would have been accepted as a faithful one a century later; yet it described a process which would have meaning for many through the whole course of the immigrant experience and even more meaning for the second and third generations, who reaped the harvest of the transplanting of their fathers without having had to suffer the ordeal.

This comment of course is well grounded for many immigrants in the later years of life. However, if it does not minimize the earlier ordeal which immigrants survived, it *does* seem to gloss over the turbulent childhood of the second generation. In any event, needless to say, the senior author had taken this view into account in framing the chapter's test hypothesis.

A third possibility is that the test hypothesis would have secured confirming data were the Midtown Study designed differently, i.e., had it sampled generation groups that stood as lineal kin to each other. Although it is difficult in a metropolis to draw a probability sample comprehending pairs of adult respondents who stand to each other as offspring to parent or grandchild to grandparent, there is more to this critical point than we realized when we planned the study. At that time, it was our implicit, unconsidered assumption that the sample's generation I would be more or less representative of the unsampled parents of the generation II respondents and that the latter, in turn, would be more or less representative of the unsampled parents of the

interviewed generation III group, etc. Therefore, we assumed that the sample would permit us to reconstruct the *unbroken* generation-to-generation progression in mental health.

The simplicity of this assumption is revealed when we examine our sample generation II in terms of a hypothetical average member. About 39 years old when we interviewed him (in 1954), "Mr. Second's" year of birth was 1915. His parents were born abroad, probably between 1880 and 1895, and migrated here most likely between 1901 and 1914.

In this connection it is relevant to recall that with a total population in 1900 of 76 million, the United States received in the following 15 years almost 14 million immigrants along with Mr. Second's parents. Involving an arrival rate of almost 1 million per year, this period (1901 to 1914) marked the flood-tide climax in a century of sustained massive immigration unparalleled in history. Dependence on the economic "crumbs" of the natives, the sheer enormity of the influx, and accelerating political disorganization of the receiving cities probably made these fifteen years the century's high point also in the survival difficulties faced by "green" immigrants.[20]

Our key question now is this: With the sample's generation II originating from immigrant parents who arrived in the climactic period 1901 to 1914, how comparable to these parents are the sample's generation I? In answer, we note that the average member of the latter group was born in 1908. In time of arrival he belongs on the whole to a new and special chapter of American immigration history, as yet largely unwritten, namely, the period after congressional passage of the acts of 1921 and 1924 that ended free immigration.

With admissions sharply reduced (to a token number of about 150,000 annually) there came a change in the make-up of the immigrants. In the first years of the twentieth century males outnumbered females by about 7:3; in the late twenties the sex ratio had changed to 5:5, and in the thirties, to 4:6. During the earlier (pre-1921) period of mass immigration the overwhelming majority of those reporting occupation had been relatively unschooled laborers from farm, village, or town. Federal sources[21] document the rapid relative increase during the "new" period of professional, semiprofessional, and other white-collar workers, a fact reflected in our sample generation I. Also, of this sample group only about one-third were from a farm or village. An additional 15% were from towns, 25% from small or middle-size cities, and 25% from big cities.[22] Finally, many of these sample immigrants were offspring of fathers who in their homeland occupations were skilled blue-collar or white-collar workers.

These and other characteristics convey a picture of decided change in make-up of the shrunken post-1921 immigration as compared with

the massive immigration waves at the turn of the century that drained large rural stretches in Europe of their young people.

Certain of the known attributes of the "new" immigrants were of a nature that would probably make for an easier and faster[23] adaptation to the American metropolis than had been the case for their predecessors. Moreover, in the interim the metropolis had itself changed—from a "vast jungle" that Lincoln Steffens stamped as "the shame of the cities" —to something more nearly approaching "community." In particular, between 1910 and 1930 Manhattan reduced its impossibly engorged resident population by almost 500,000. On both counts, therefore, it doubtless could more easily and humanely accommodate the smaller company of newcomers than had been possible for the hordes who had come earlier.

All told, therefore, the *Sturm und Drang* ordeal of exile we have come to associate with the pre-1921 immigrants appears likely to have diminished for their post-1921 successors. Better equipped for metropolitan life and probably better received, our sample generation I group could plausibly be expected to appear with less wear and tear of mental health than had their predecessors by two decades at the same stage of life.

Thus, if in Table 14-2 above we find no difference in mental health composition between the sample's generations II and I we can infer that were comparison possible between group II and their own parents, such a difference would likely have been found in the direction suggested by this chapter's test hypothesis.

IMMIGRANTS' PARENTAL SES, RURAL-URBAN ORIGIN, AND MENTAL HEALTH

This line of reviewing the overlooked implications of historical changes in the immigration stream led us to reexamine the generation I group. There we conducted an analytical search for respondents who would most closely exemplify the old and the new immigrant populations. From this dissection we were able to isolate two extreme types. Type O is the nearest approximation in two respects to the kind of individual who dominated the older, pre-1921 immigration; that is, these respondents are from Europe's farms, villages, or small urban places and derived from parents who were low (E–F) in our SES-origin scale. Type N, on the other hand, represents in two respects the newest element appearing in the post-1921 immigration, namely, those who came from Europe's big or medium-size cities and out of families who stood in the higher strata (A–D) of our SES-origin ranking. In Table 14-3 these two types and the totality of generation I, standardized for age, are seen

in their distributions according to the psychiatrists' classification of mental health.

Table 14-3. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Types of Immigrants as Standardized for Age

Mental health categories	Type O	Type N	Total generation I
Well	10.2%	17.9%	16.0%
Mild symptom formation	30.8	40.5	37.2
Moderate symptom formation	24.7	23.1	21.2
Impaired	34.3*	18.5*	25.6
N = 100%	(163)	(185)	(593)
Sick-Well ratio	336	103	160

* $t = 3.4$ (.001 level of confidence).

Thus, had type O been predominant in our sample generation I group (as it had in the earlier period of immigration), it seems clear that the mental health difference we originally hypothesized for generations I and II would likely have received the support of the Midtown data.

The pronounced difference we see above in types O and N suggests that what is decisive among immigrants is not transplantation to the American metropolis per se, but resettlement in the American metropolis from a *particular kind* of overseas milieu, namely, from the low socio-economic strata in farm, village, or town. In this perspective, "foreignness," in the nationality and linguistic sense alone, may involve certain initial difficulties for the immigrant from the middle or near middle-class strata of European cities. But these difficulties in themselves probably are minor in significance and relatively brief in duration, at least compared to the situational and adaptational burdens that descend when the immigrant combines this foreignness of nationality with other special dimensions or meanings of the word *foreign.* Those dimensions hinge on the contrast between the involuted complexities of Manhattan and the simple way of life in Europe's rural places as delineated with great artistry in a novel like Reymont's *Peasants*[24] or in Gavin Maxwell's[25] book portraying an economically depressed Sicilian village. The contrast stretches in time from the somnolent agrarian, preindustrial order characterizing the early nineteenth century to the twentieth century's summit point in the industrial cosmopolis. To compress the profound historical changes of a revolutionizing century into a few adult years of an individual life cycle may exact a high price in psychological well-being, such as is intimated in the mental health distribution of type O immigrants seen in Table 14-3.

If this formulation accounts, at least in part, for the mental health differences between types O and N, perhaps primarily responsible is not the character of the environment at the immigrant's point of origin in itself, but its distance in "social time" from New York and the rush with which the O type immigrant had to accomplish his sociopsychological vault from one to the other. Thus, divergence between O and N immigrants in their Impaired-Well balance may reflect different magnitudes of role discontinuity bridged in the transition from their respective native environments.

Within the framework of the generation-in-U.S. variable, immigration from abroad, at least on the part of adults, is usually a motivated act; as such, personality differences may be associated with the distinction between the self-chosen migrants and their nonmigrant townspeople.[26] We can asume that *self-choice* was maximally involved among generation I respondents who migrated "on their own steam" as isolated adult individuals, involved to a lesser degree among adults who migrated with family or settled with kin, and involved negligibly among those who, as children, were brought to this country by their parents. On the criterion of their present mental health composition, at least, these three subgroups of immigrants emerge without any significant differences.

This bit of evidence is suggestive but hardly conclusive on the issue, since the three subgroups may deviate psychologically in similar fashion from the nonmigrants. In part they could deviate not only by the processes of subjective selection, but also as a consequence of the objective selection engineered through the screening apparatus of the United States government. By way of explanation: "The visa requirement established by the Immigration Act of 1924 is in itself an important regulative device. . . . In order to secure a visa an immigrant must have established his eligibility to enter the United States, a process requiring many documents with respect to the identity, character and financial standing of the applicant. The overseas issuance of visas has proved an effective means . . . of screening immigrants prior to entry." [27] According to an official document,[28] beyond rejecting those "likely to become a public charge," such screening also rejects individuals who "are not mentally sound and physically fit [or are] drug addicts and chronic alcoholics [or are] over 16 years of age [and] cannot read and understand some language [or] have committed a crime. . . . In short, an alien who does not measure up to the moral, mental, physical and other standards fixed by law is subject to exclusion, or [after admission] may be deported to the country from which he came."

This is a formidable screen, especially for personality deviants of all kinds, both as it is directly applied to visa applicants by American overseas consulates and as an indirect restraint in discouraging applications.[29] The threat of rejection, or of acceptance and subsequent de-

portation, is known to be taken into grim account by potential applicants.

Under such screening, direct and indirect, this seems certain: Winnowed of those already sick in mind or body and probably of many others representing gross risks in such directions, immigrants of the past four decades have been a selected, more homogeneous population in mental health respects as compared to their nonmigrant fellow townspeople.

Moreover, the steady stream of returnees to the homeland[30] is evidence suggesting that the nonreturnees have been further sifted of those who could not adjust to the difficult demands placed upon the immigrant new to America and to the metropolis.

These points have been developed here on the same rationale that prompted a parallel discussion of marital status in Chapter 10, that is, to underscore the probability that the sample immigrant group, including type O itself, being largely post-1921 in arrival date, is a residue of multiple winnowing processes.

On the one hand, this may shed light on a fact previously unattended in Table 14-1, that among its four groups the incapacitation rate of generation I is no greater than that of the rest. On the other hand, it leads us to a reconsideration of the earlier immigrants who were the parents of our generation II respondents.

A decisive fact is that this earlier wave of immigrants arrived before establishment of the United States visa-screening apparatus. Thus, it is almost certain that they had a substantially greater representation of mental illness risks than did the later immigrants. Also more numerous in the earlier wave of immigrants was the type O background that we now know, from our post-1921 sample immigrant group, to be particularly associated in Midtown with a high mental morbidity rate.

On both of these counts, there are ample grounds for the expectation that our generation I respondents as an aggregate are better off in mental health respects than the immigrant parents of our generation II had been at the same age. Second, according to our original test hypothesis, we expect that our generation II respondents are also in better mental health composition than their parents had been at the same age. Third, if indeed both sample generation I and sample generation II are healthier than the latter's unstudied immigrant parents had been, then it could have been hypothetically predicted that these two sample groups would not be far apart from each other in this respect. Of course, Table 14-2 offered evidence that when respondent age and SES origin are held constant, these two generation groups are almost identical in their mental health distributions.

All in all, reconstruction in terms of the probable differential effects of selection processes on the earlier and more recent waves of immigrants, together with the direct evidence from immigrant types O and

N appearing in Table 14-3, represent separate lines of analysis that lead to the same conclusion: Far from rejecting the test hypothesis predicting mental health differences between immigrants and their native-born children, the data in Table 14-2, historically interpreted, seem to stand in support of that hypothesis.

PARENTAL SES, THE URBAN-ORIGIN VARIABLE, AND MENTAL HEALTH AMONG THE U.S.-BORN

In Table 14-2 generations II and III also appear to contradict our original hypothesized predictions for these groups. Here again, processes of self-selection may have unexpectedly intruded to complicate the picture.

Although we had always seen generation I as open to self-selection processes, we had viewed a position in generation II, III, or IV as a matter of descent and therefore independent of individual influence or choice. We had also been aware of the fact that about half of the U.S.-born people in Midtown were themselves in-migrants from birth places reaching to the four corners of the nation. To be sure, like immigration of the foreign-born, in-migration of the native-born is a motivated act, usually self-determined, and therefore amenable to the influences of subjective selectivity.

However, in the absence of census data on this point, we had simply assumed that the weightings of in-migrants among generations II, III, and IV would not be grossly different. When the Midtown sample data were in and analyzed, however, we found that this assumption had been erroneous. The analysis revealed that in generation II a minority of 35% are in-migrants from the rest of the country, i.e., 70% are native New Yorkers. On the other hand, in generation III the in-migrant proportion rises to 47%, and in generation IV it jumps to a commanding majority of 72%, i.e., only 28% are native to the City. In short, the seemingly independent variable of generation differences among the U.S.-born respondents proves to be entwined with the reciprocal variable of in-migration from communities large and small on the continuum of American rural-urban places.

It is possible that mental health differences selectively associated with in-migration tend to obscure the expected decrease in the impairment rate from generation II through IV. This possibility can be checked, although under some handicaps. First, generations III and IV, each with about 250 respondents, are too small to sustain analysis of the in-migration factor while also controlling for both parental SES and age. Accordingly, for this purpose we have no choice except to combine the two generations in one group. This is unfortunate because it will blur the close comparison of generations II and III that we seek to make. Even

so, the merged group, i.e., III–IV, has too few respondents of low SES origin for reliable treatment of the latter.

Confining ourselves to the middle (C–D) and upper (A–B) strata, we find these countertrends in both SES-origin classes: (1) among the sample's native New Yorkers, generation II emerges with a higher Sick-Well ratio than does group III–IV (with age standardized in all instances); (2) among the in-migrants the reverse obtains; i.e., here generation II has a smaller Impaired-Well imbalance than do the group III–IV respondents. By way of illustration, we offer the Sick-Well ratios in the four subgroup cells representing the middle SES-origin stratum:

	Native New Yorkers	In-migrants
Generation II	140 (N = 178)	63 (N = 90)
Generations III–IV	99 (N = 68)	90 (N = 82)

If we focus only on the native New Yorkers in the left-hand column above, the generation difference in balances of Impaired and Well people is in the direction originally hypothesized. However, the in-migrant generation II respondents are the healthiest of the four subgroups, and their weight is sufficient to counterbalance the generation difference observed among the New York–born.

That the intergeneration difference among in-migrants (right-hand column above) is not in the hypothesized direction may be largely a function of differential subjective selectivity for movement to New York, operating in ways we cannot document or reconstruct as yet.[31] On this open-ended note we can at least draw this inference: Table 14-2 offers no warrant to reject the original hypothesis positing that mental health composition would be less favorable in generation II than in III.

The identification of types O and N among immigrants hinged on the factor of rural-urban community settings during childhood abroad. To round out this exploration, we can next apply the same variable[32] to the U.S.-born respondents (generations II to IV inclusive).

There are too few of these respondents reared in a farm or village community to be included while controlling for SES origin and age. Accordingly, the categories examined can cover only the broad urban range and include (1) town or small city, to be abbreviated as *town*, (2) medium or big city (excluding New York City), designated *City*, and (3) *New York City*.

Among American-born adults of low (E–F) parental SES, mental morbidity rates, with age standardized, do not vary with the urban-origin factor so categorized. Along the remainder of the SES-origin

range, however, there are noteworthy mental health differences. These are reported in Table 14-4.

Table 14-4. *Home Survey Sample* (Age 20–59), Distributions on Mental Health Classification of U.S.-born Respondents by Urban-origin Types as Standardized for Age and Parental SES (Inclusive of SES Strata A–D only)

Mental health categories	Urban-origin type		
	Town	City	N.Y.C.
Well	26.6%	24.7%	19.2%
Mild symptom formation	34.3	40.3	36.8
Moderate symptom formation	26.0	16.2	22.5
Impaired*	13.1	18.8	21.5
N = 100%	(173)	(170)	(386)
Sick-Well ratio	49	76	112

* $x^2 = 5.51$, $2df$, $p > .05$.

Although the relationship of impairment rates to urban origin here verges on statistical significance (slightly below the .05 level of confidence), the trends in both Impaired and Well frequencies are consistent in their respective directions.[33] Here we see a reversal of the trend previously observed in generation I. Among the latter, Sick-Well values of *greatest* magnitude were isolated in low SES-origin immigrants from the smaller, principally rural, communities abroad. In Table 14-4, the Impaired-Well ratios of *least* magnitude are noted in Midtown respondents from the nation's smaller urban places. The facts that their childhood communities were American and urban and that their parental-SES derivations were in the upper two-thirds of our SES-origin range together offer the reasonable inference that no adaptive problems of sharp change in environment had here been involved.

Instead, we are left with two alternative explanations for this discerned mental health trend on the American urban-origin variable. The first is that the three urban-origin types more or less accurately reflect mental health differences in the like-age-and-SES segment of the parent American communities. Under this assumption, then, the smaller the urban community in which American middle- and upper-status children grow up, the better are their mental health chances when they reach adulthood. If this should be the case, New York City would appear to be the least favorable place to rear such children.

The second possible interpretation proceeds from a far more complicated framework. To begin with, it asserts that in most American communities the indigenous *permanent* residents as a rule far outnumber the

native-son *emigrants* who settle elsewhere. On this ground of much greater numerical strength, the indigenous residents are likely to be more representative or reflective of the community's mental health productivity than are the minority of native-son emigrants.

By this line of reasoning, the native New Yorkers in Table 14-4 probably are not far different in mental health make-up from the population universe of New York–bred adults of the specified age and parental SES. On the other hand, the in-migrants seen in Table 14-4 are less likely to be representative of mental health conditions among like-age-and-SES people in their *home* communities.

Third, this approach also takes into account the fact that emigrants from a given community, in moving to their adopted places, travel varying "distances" in the social dimensions of the rural-urban continuum.[34] In this sense, the town group appearing in Table 14-4 has traveled farther to settle New York than has the city type. Next we can posit as a consequence of subjective selectivity that personality and mental health differences divide those who in this sense travel near ("hoppers") from those who move far ("vaulters"); specifically, of these two categories of emigrants from the same childhood community, the vaulters may deviate farther from the mental health composition of their common population of origin than do the hoppers.

As to how representative the three groups in Table 14-4 are of their respective parent populations, by this formulation the New York–born respondents are the most representative and the town in-migrants are the least. Since we have reason to believe that such town-to-metropolis traffic is an important facet of upward SES mobility, as discussed in Chapter 12, it seems likely that both types of Midtown in-migrants were actually more favorable in mental health composition than were their respective back-home populations of like-age-and-SES origin. Accordingly, from the town and city groups in Table 14-4 we cannot generalize that the smaller the urban community in which middle- and upper-class American children live, the better are their mental health chances as adults. In contradicting the first interpretation suggested by the data in that table, this formulation[35] takes the cautious position that the important issue highlighted by that interpretation is still wide open for lack of relevant evidence from other urban populations.

TREATMENT CENSUS FINDINGS

In the Midtown Study the factor of treatment was covered, although in very different ways, by both of our major research operations. One was the Treatment Census, with its goal of enumerating all Midtown residents in the care of psychotherapists at a given point of time. The other was the Home Interview Survey, in which we asked each sample

respondent whether he had ever been to a psychotherapist, and if so, when. (For characteristics differentiating the Home Survey operation from the Treatment Census see Chapter 8.)

It has been our consistent effort to relate Midtown data bearing on the demographic factors to recently published studies that are substantively or technically relevant and challenging to the present investigation. Pertinent to this chapter is a monograph that has appeared under the sponsorship and imprint of the Social Science Research Council (SSRC) and its Committee on Migrant Differentials. Entitled *Migration and Mental Disease,*[36] the monograph includes an introductory chapter by Dorothy S. Thomas, chairman of the stated SSRC committee.

Since this work presents the most up-to-date views on the migration factor (both immigration and in-migration) and its links to treated mental disorder, we are called upon to take it into serious account by way of providing a backdrop for the Midtown treatment data.

The general mandate of the SSRC committee has been to consider in what respects migrants are different from nonmigrants. The monograph reports its examination of mental illness as one of the possible differentials. Reviewing the relevant literature up to 1953, Thomas in her introductory chapter indicates that the most rounded work in this field had been done by Odegaard, the Norwegian psychiatrist, and Malzberg, the American statistician. Both of these investigators took first-admission patients of mental hospitals as their criterion of the frequency of mental illness.[37]

As indicated in the Thomas chapter, Odegaard's study[38] is probably unparalleled. He compared the public hospital rates over a forty-year span (1889–1929) of Norwegian-born immigrants in Minnesota with those (1) of the total native-born population of Minnesota and (2) of the total population of Norway, with standardization for age and sex differences. Odegaard found the Norway-born Minnesotans to have patient rates higher than those of U.S.-born Minnesotans; the latter, in turn, had rates higher than those of the population in Norway. In short, *both* U.S.-born and Norwegian-born Minnesotans had higher hospitalization rates than did the population of Norway. Odegaard notes that differences in

> . . . the hospital facilities of the two countries may to some extent explain this, but of course nothing definite can be known about them. . . .[39] The discrepancies [between hospital patient rates in Minnesota and Norway] seem too large for such an explanation to be entirely satisfactory, and it is probably safe to assume that there is actually more insanity among native-born Minnesotans than in the population of Norway. This is in fact very natural, if, as we have some right to believe, there is a connection between immigration and mental disorders. During [1890–1900] about 33 per cent of the native-born [Minnesotans] were actually [in-migrants] from other states in the Union,

mostly the East. . . . The factors which tend to increase the incidence of mental disease in the Norwegian immigrants [to Minnesota] will therefore probably to some extent be at work in one-third of the native-born also [i.e., in the U.S.-born in-migrants to Minnesota].

Odegaard sees two main factors as explaining "the natural . . . connection between immigration and mental disorders." One is the "mental and physical strain" of resettlement; and this, for him, applies both to the Norwegian and Yankee settlers of Minnesota. The other, more heavily emphasized element is the "prevalence of certain psychopathic tendencies in the constitution of those who emigrate. Emigration is frequently a result of the restlessness and difficulties of adaptation which may at times be a basis for a later psychotic development."

For our present purposes, the principal difficulties in Odegaard's investigation lie not in the sweeping generality of its etiological conclusions, but in the inadequacy of its data to support etiological inferences of any kind. The root difficulty is the author's assumption that variations in hospitalization rates among the three population groups under study adequately reflect differences in their over-all frequencies of severe mental illness. This assumption may perhaps be valid in some places and not in others and at some points of time and not at others. Accordingly, there is no warrant to impute varying characteristics to community groups on the basis of intergroup differences in hospital rates if the validity of this assumption at the particular places studied is unknown. This precaution is especially indicated by the simple fact that variations in the bed capacities of mental hospitals rather than a presumed constitutional etiology tend to determine the number that can be institutionalized.[40]

In a subsequent paper[41] Odegaard takes note of such criticisms. He suggests that the goal of such research is "not to obtain a higher degree of completeness by extending the concept of mental disease, but to establish some definite limitation to make it possible for various authors to compare results." For this purpose,

. . . hospital admission is, in borderline cases, the only distinctive landmark; and besides, it is not at all without clinical meaning. Practically all psychoses with definite clinical symptoms will at some time necessitate admission. At least this is so for schizophrenic and allied disorders and for general paresis, although for the depressive psychoses it may be more doubtful. For senile psychoses, and for psychoses with mental deficiency and epilepsy, on the other hand, hospitalization will frequently be dependent more upon social than upon clinical factors; and admissions for those diagnostic groups do not allow any safe conclusions as to the incidence of the disease.

To round out, if hardly to close this debate, several observations can be addressed to Odegaard's comments. First, as reported earlier (Chapter 8), the Midtown Treatment Census found that in *ambulatory* care

were 36% of all reported nonparanoid schizophrenic patients and 14% of all paranoid schizophrenic patients. Second, from other studies there is evidence indicating that when hospitalization does eventuate it often does so long after psychotic symptoms first appeared.[42] Furthermore, the effort to secure psychiatric treatment of any kind often depends upon social factors like a break in family or local tolerance of the symptoms, precipitating, if not a first recognition of "illness," at least a change in the previous view that the condition is "harmless."

Finally, in the whole battery of possible social elements impeding the family from committing a member to a hospital, one potentially affecting immigrants in particular is noted by Malzberg and Lee:[43] "It is claimed that recent immigrants may sometimes be sent to hospitals for mental disease with reluctance because of the possibility of deportation on the ground that the disease was contracted before entry into the United States."

All in all, there are ample grounds for questioning confidence in the inevitability that any of the more frequent psychotic disorders "will at some time necessitate admission to a mental hospital."

Also worthy of attention is Odegaard's hypothesis that immigration tends to recruit people predisposed to mental disorder, with the obverse implication that nonmigrants tend to be selectively less predisposed. That migrants and nonmigrants are selectively different in such characteristics as mental health seems to be a plausible hypothesis. But that such selection operates in the direction suggested by Odegaard has yet to be established.

As mentioned earlier in the present chapter, we can test this hypothesis in the Midtown sample's immigrant group by dividing it into three subgroups: (1) those who came to the United States as children and therefore are not self-selected migrants; (2) those who came as youths in the company of parents or kin, with the element of self-determination of the migratory act somewhat ambiguous; and (3) those who came unaccompanied, as youths or later, most probably a self-selected group. To corroborate Odegaard's postulate, group 3 should have the highest impairment rate and group 1 the lowest. However, the data for these three subgroups show no differences in their Impaired or Well frequencies. There is no endorsement in these Midtown data for the view that the self-recruited newcomers who initiated their own immigration to the United States have a higher rate of mental morbidity than the less selected who were brought on the initiative of others.

The main body of the SSRC monograph is the study report contributed by Malzberg and Lee. In their own opening chapter, these authors[44] take note that from

> . . the literature on this subject, it is generally concluded that the incidence of mental disease is higher among migrants than among non-migrants, and that

the difference is attributable either to selection of poorer risks at places of [migrants'] origin or to stresses of migration and adjustment at places of destination. Most of these differences have been based on scanty or otherwise inadequate data, and even the fact of higher incidence of mental disease among migrants is not firmly established, much less the theories as to cause.

Their study covered all residents of New York State who were first-admission patients in hospitals supported by the state or Federal government (VA) and in state-licensed private hospitals during the three fiscal years ending June 30, 1941.[45] For the white population only, Malzberg and Lee report these average annual rates of hospital first admissions (per 100,000 population), as standardized for age:

Foreign-born males	156
Native-born males	140
Foreign-born females	143
Native-born females	118

Thus, among these four groups only the U.S.-born females deviate in their rate to any extent. Moreover, most of their deviation from the other three groups is traceable to the age range above the 60-year line.[46] There is the definite impression that many senile U.S.-born women are placed for custodial care in nursing homes.

With this evidence suggesting little difference in hospitalizations between immigrants and U.S.-born in the white population of New York State, Malzberg and Lee concede that[47]

> . . . rates of first admission are far from ideal indicators of the incidence of mental disease, but for our purposes they are the best available. It is impossible to determine the number of persons who each year become psychotic because many persons with psychoses may not be included in the statistics of mental disease. There are persons who would be considered psychotic by psychiatrists but who are never treated or diagnosed. Others are treated privately but never hospitalized, and their cases are not reported. [Later they elaborate that] comparisons of migrant and nonmigrant populations are affected to an unknown extent by differential ability or willingness to care for mentally ill persons at home.[48]

The reservations placed by Malzberg and Lee on hospital patients as study populations are shared by the present authors. However, to the view that such patients are "the best available" indicators of the frequency of mental illness we must counter that *best available* does not necessarily imply *good enough* for the kinds of generalizations drawn from them.

In the New Haven study alluded to in previous chapters, the scope of coverage for the first time encompassed ambulatory as well as hospital patients and used prevalence instead of incidence as the measure of frequency. For the demographic factor of concern to this chapter, the New Haven investigators report only for foreign-born and native-

born above the age of 20.[49] From distribution data published, we calculate Total Patients rates of 1,169 per 100,000 immigrants and 1,005 per 100,000 of the American-born population. However, even within the adult age range immigrants are decidedly the older of the two groups, and therefore standardization for age is indispensable. Such standardized rates have not yet been reported. However, the effect of such standardization can be anticipated from the results secured when we remove cases diagnosed as disorders of senescence[50] from the patients of both New Haven generation groups. When this is accomplished, the rates per 100,000 among adult immigrants and natives are reduced to practical identity. We might note in passing that this "no difference" parallels the New York State findings.

We turn now to the cases of the Midtown Treatment Census. On the basis of institutional records, hospital and clinic patients could be classified into three generation-in-U.S. groups paralleling the Home Survey sample's I, II, and III–IV. On the patients of office therapists no data identifying generation level were secured. We are therefore extrapolating estimates of office patients from the current patients[51] identified in the Home Survey sample. Because these estimates relate to the 20 to 59 age range, in Table 14-5 we are including only hospital and clinic patients who are within this age span.

Table 14-5. *Treatment Census* (Age 20–59 Only) Prevalence Rates (per 100,000 Population) of Midtown Patients by Type of Service and Generation-in-U.S.

Treatment sites	Generation groups		
	I	II	III–IV
Hospitals	504	829	298
Clinics	76	210	89
Office therapy*	430	2,058	4,811
Total Patients rate*	1,010	3,097	5,198

* Estimated.

To what ends can tables like this be put? In concrete terms, they serve to map the patient traffic in terms of (1) its volume, (2) its differential group origins in the community population, and (3) its flow toward different destinations among the various types of available treatment facilities. Such information, in turn, can have important implications for policy decisions in planning service programs. By way of a single example, we know office therapists are treating psychotics in considerable numbers, diverting them from hospitalization—especially, we now discover, in generation group III–IV. Ambulatory treatment in clinics could

probably serve the same purpose for generation I and II people who cannot afford high-cost private therapy. But, Table 14-5 indicates that those clinics available to Midtowners serve *adults* of *all* generations to a negligible degree. Clearly, such knowledge can guide plans for the expansion of treatment facilities that will inevitably come.

There is one function Table 14-5 clearly cannot serve: It cannot offer any ground for proceeding from known demographic differences in frequencies of *treatment* to inferences about frequencies of *illness* still unknown. To fix the point, we might compare Tables 14-1 and 14-5 in this chapter, both having reference to the age 20 to 59 Midtown population. Among the three generation groups in Table 14-5, the hospital rate of generation II is substantially highest and of III–IV the lowest. In Table 14-1, Incapacitated is a category in Rennie's classification scheme that is the closest available approximation to the criterion of *hospitalizable.* According to that table there are *no* significant generation differences in the proportions of these noninstitutionalized Incapacitated people. The generation trends of the Incapacitated and of the Hospitalized bear no resemblance to each other.

Or, in Table 14-5, let us take the clinic *and* estimated office treatment rates which, together, *rise* from 506 in generation I to 4,900 in group III–IV. In Table 14-1, the mental health categories designated Impaired-Severe and Impaired-Marked could be expected to delineate the reservoir of potential eligibility for ambulatory treatment. The joint frequency of these two categories *declines* from 24.3% in generation I to 19% in group III and 14.6% in group IV. In short, the two trends on the generation variable move in opposite directions.

The objection may be made that these cross-directional findings on the generation pyramid are chance or freak incongruences that are of no general significance. In rejoinder, it should be noted first that a similar phenomenon has already been reported in previous chapters for the age and socioeconomic status factors and will be encountered again in the chapter on religious groups.

Second, that treatment rates may vary in ways different from morbidity rates can be demonstrated if a criterion group of known mental morbidity cases are circumscribed and treatment rates then are shown to vary among them with differences in demographic characteristics. Equally important is that this will bring to bear data on that part of our key question which asked: What kinds of sick people do *not* get treatment?

HOME SURVEY SAMPLE: HELP-NEED AND THE PATIENT-HISTORY VARIABLE

Toward these ends, we would now return to our age 20 to 59 Home Survey sample, where the Study psychiatrists have placed 389 respondents

in the Impaired category of mental health. Despite apparent limitations, this category in the sample has served as our working criterion of potential need for professional help.

It will also be remembered that on the basis of interview material we were able to classify all sample respondents on a variable we call *patient history*. Those who had never been in one or more professional sessions with a psychotherapist are never-patients; those who had been in such a session during the previous month are designated current patients; and the remainder who had ever been to a therapist are ranked as ex-patients.

In Table 14-6, only the Impaired in each generation group are shown in their distribution on the patient-history variable. Because of their small numbers the Impaired of generations III and IV are here combined.

Table 14-6. *Home Survey Sample* (Age 20–59), Distributions of Impaired Respondents on Patient-history Classification by Generation-in-U.S.

Patient-history	Generation groups		
	I	II	III–IV
Current patients	0.6%	4.6%	14.3%
Ex-patients	16.5	24.4	25.5
Ever-patients	17.1	29.0	39.8
Never-patients	82.9	71.0	60.2
N = 100%*	(158)	(131)	(97)

* Three Impaired respondents are of unknown generation.

Table 14-6 indicates that among Impaired respondents the ever-patient rates increase in regular progression up the generation scale. If the increase is far sharper for current patients than for ex-patients, we can assume that among the latter are mixed the formerly hospitalized, whose rates by generation vary in a direction opposite to the probable trend in the ambulatory ex-patients.[52]

Two important questions remain open: Do these patient-history differences genuinely adhere to the generation factor independently of other demographic factors? Or are these differences entirely the indirect reflection of more powerful demographic variables that are concealed in the generation factor? That these questions are decidedly in order is indicated by the facts revealed in previous chapters that ever-patient rates among the Impaired are largest in the younger and higher own-SES segments of the Midtown sample population. The latter are of course underrepresented in generation I.

To answer these questions we shall convert the data in Table 14-6 by standardizing the Impaired category in each generation group to a hypothetical ideal population.[53] The results appear in Table 14-7.

Table 14-7. *Home Survey Sample* (Age 20–59), Distributions of Impaired Respondents on Patient-history Classification by Generation-in-U.S. as Standardized for Own SES and Age

Patient-history	Generation groups		
	I	II	III–IV
Current patients	1.1%	11.0%	13.4%
Ex-patients	13.8	25.5	22.4
Ever-patients	14.9	36.5	35.8
Never-patients	85.1	63.5	64.2
N = 100%	(158)	(131)	(97)

In this table we discern that the marked difference in current-patient rates previously observed between II and III–IV is erased. The conclusion seemingly to be drawn is that when age and own SES are controlled, the tendency of the Impaired to be treated in an ambulatory setting splits rather sharply on the line dividing the immigrants from the American-born generations. That is, among the Impaired those with the highest ever-patient rates are U.S.-born younger adults (age 20 to 39) of higher socioeconomic status. Whereas lagging far behind in such rates are the older adults (40 to 59) of lower SES and foreign birth.

HELP-NEED AND PROFESSIONAL ORIENTATION

We have seen earlier in this chapter that among Midtown sample adults mental health distributions do not vary with generation-in-U.S. level when parental SES and respondent age are controlled. Furthermore, we have just observed that within the criterion Impaired category, when own SES and age are controlled, ever-patient rates are at the same relatively high point in generations II and III–IV and substantially lower only in the immigrant group.

The question is now raised about the relative extent of *effective* demand for professional help that exists among Impaired respondents in the several generation groups. To this end, the effective demand can be judged by their replies to two interview questions that were put to all respondents. The questions inquired about the nature of the advice the respondent would give if such counsel were solicited by a friend concerned about "what to do" (1) with a problem child and (2) with a problem spouse. Respondents were classified according to the most specialized kind of professional help they would recommend for either or both problem situations. In so doing we can assume they reveal, by indirection, what kind of professional help they are themselves aware of and disposed to seek. In Table 14-8, the Impaired respondents in

each generation group, as first sorted by own-SES class, are shown with the proportion who recommended psychotherapy in their replies.

Table 14-8. *Home Survey Sample* (Age 20–59), Proportion Recommending Psychotherapy among Impaired Respondents by Generation-in-U.S. and own SES

Own-SES classes	Generation groups		
	I	II	III–IV
Lower (E-F)	12.4%	13.1%	10.7%
N = 100%	(97)	(61)	(27)
Middle (C-D)	9.8%	32.7%	40.0%
N = 100%	(51)	(52)	(30)
Upper (A-B)	—*	55.5%	60.0%
N = 100%	(10)	(18)	(40)

* These cases are too few to present a meaningful percentage.

In positive orientation to or awareness of psychotherapy among Impaired respondents, lower-SES respondents in the U.S.-born generation subgroups are as often remote as are the foreign-born. Among the upper-status respondents the pro-therapy proportions are far higher but again more or less uniform among the generations. With the middle-stratum Impaired cases, the pro-therapy rates split sharply on the line dividing the foreign-born from the natives. Stated differently, higher frequencies of potential demand for psychiatric care seem to be localized among the American-born Impaired people of the upper two-thirds of the own-SES range.

SUMMARY

We might now briefly retrace the ground we have traversed in this chapter's coverage of the generation-in-U.S. variable.

1. On the foundations of the large literature reporting observations of American immigrants and their children, it was hypothesized that mental health would be most unfavorable in generation I and would be progressively more favorable in successive generation groups from II through IV.

2. As distributed on the psychiatrists' mental health scale, the four generation groups in the Midtown sample emerged with Impaired and Well differences that leaned in the hypothesized direction. However, these differences were relatively small in magnitude except between the two anchoring groups—I and IV.

3. When the age and SES-origin factors entangled with the generation variable were controlled by standardizing, the original Impaired-Well

differences observed were practically erased. With no evidence of mental health differences specifically attributable to the generation variable apart from the age and SES-origin factors, rejection of the tested hypothesis was indicated.

4. The face implausibility of this "no relationship" finding prompted a critical reexamination of our assumptions and methods. A number of these were seen to be grossly simplistic. However, reanalysis of the data in the light of the overlooked complexities suggested that (*a*) at the very least, the data do not warrant rejection of the chapter's major hypotheses; and (*b*) with considerable probability, the data seem to support these hypotheses.

5. In the course of this dissection we discovered in the sample's immigrant group that relatively frequent incidence of mental morbidity was associated with the combination of lower parental SES and a rural-town childhood background. Conducting a similar exploration among the sample's American-born respondents (generations II to IV), we found urban-origin differences in mental health only within the middle and upper brackets of parental SES. With the urban-origin variable classifying Midtown respondents according to town, city, or New York derivation, mental health composition was most favorable in the town category and least favorable among the native New Yorkers. Two contradictory interpretations of this trend were discussed.

6. Turning to the factor of psychiatric treatment, we reviewed three recent studies that focused on immigrants and the native-born among psychiatric patients. Noted were differences in the findings and inferences they generated. Also brought to bear were the generation data yielded by the Midtown Treatment Census, with emphasis on their special utility and their specific limitations.

7. Returning to the Midtown Home Survey, those in the sample's Impaired category, taken as criterion of professional help-need, were analyzed by generation groups for differences in patient history. Upward on the generation scale the ever-patient rates increased and the never-patient rates diminished. However, with standardization for own SES and age, the trend changed to a dichotomy that broke sharply on the line dividing the Impaired immigrants from the Impaired native-born groups. Compared to the latter of like age and socioeconomic status, the foreign-born Impaired people get to a psychotherapist to a considerably lesser extent.

8. On an indirect test of awareness of and disposition to seek psychotherapy among Impaired respondents, again the U.S.-born of middle and upper own-SES strata were far ahead in their pro-therapy frequencies. This roughly delineates the locus of effective demand for professional intervention among Midtown's help-needy adult residents.

FOOTNOTES

[1] Placement in a generation group was made not on the judgment of the respondent but on that of the interviewer and was subsequently checked by office staff.

In classifying the Midtown sample, all U.S.-born respondents who had one foreign-born parent and the other of American birth were arbitrarily placed in generation II. This mixed subgroup numbered about one-fourth of all sample respondents assigned to generation II. Similarly, all U.S.-born respondents with both parents of native birth were placed in generation III if one to four grandparents were foreign-born. Approximately half of all sample respondents classified as generation III had from one to three U.S.-born grandparents. Because the mixed subgroups of generations II and III are not significantly different in their mental health composition from their unmixed generation peers, they will not be differentiated in the data analysis that follows.

[2] In the interest of conserving interview time, the identification of such respondents' immigrant forebears was not pursued beyond the question, "About how many generations before your father's parents did his family come to the United States?" With an identical question for mother's family, the answers ranged from respondent's great-grandparents to ancestors dating back to the eighteenth and seventeenth centuries. Thus, the category of generation IV for a respondent should be understood as referring to four or more generations in the United States on *both* his father's and his mother's side.

[3] By sample design only one age-eligible occupant was drawn from each randomly selected dwelling. Furthermore, in a metropolitan area like Midtown the chances are slight of drawing two linear kin from separate households. To our knowledge no generation II respondent is either offspring of a generation I respondent or parent of a generation III respondent.

[4] Four U.S.-born respondents terminated the interview before the generation section was reached. However, the symptom coverage was sufficient in scope for mental health evaluation, permitting their retention in the interviewed sample.

[5] M. Lerner, *America as a Civilization*, 1957, p. 476.

[6] E. N. Saveth, "Good Stocks and Lesser Breeds: The Immigrant in American Textbooks," *Commentary*, vol. 17, no. 10, pp. 494–498, May, 1949.

[7] *Ibid.*, p. 498.

[8] Oscar Handlin, *The Uprooted*, Boston, 1951.

[9] *Ibid.*, p. 6.

[10] *Ibid.*, pp. 155–164.

[11] For a field study of variations in these conflict situations among eight different immigrant groups, of W. L. Warner and L. Srole, *The Social Systems of American Ethnic Groups*, 1945, pp. 124–155. Also, I. L. Child, *Italian or American? The Second Generation Conflict*, 1943; W. I. Thomas and F. Znaniecki, *The Polish Peasant in Europe and America*, 1918; and P. J. Campisi, "The Italian Family in the United States," *Am. J. Sociol.*, vol. 53, no. 6, pp. 443–49, May, 1948.

[12] K. Lewin, *Resolving Social Conflicts*, 1948, pp. 186–200.

[13] M. Hansen, "The Third Generation in America," in *The Immigrant in American History*, 1940. See also S. Koenig, "Second and Third Generation Americans," in F. J. Brown and J. S. Roucek (eds.), *One America*, 1952.

[14] Average age in generations I and II is 46 and 39, respectively; in both III and IV it is 36.

[15] Since we shall use this device in subsequent chapters, considerations of inter-chapter comparability suggest that the same kind of standard population be applied throughout. To this end, it is necessary to construct a hypothetical ideal standard. In the present instance, the standard generation group is one constructed to be equally distributed among the six cells (i.e., with 16.7% of the group's population in each cell) that are produced when parental SES is trichotomized (lower, middle, upper) and respondent age in each SES stratum is dichotomized (20 to 39 versus 40 to 59). Calculations are then made of the mental health distributions that would have emerged from the four generations so identically constituted.

[16] For the record, we would note also that no significant differences in mental health composition emerge when we sort out and compare males and females in each of the four generation groups.

[17] To be sure, generation IV splits 2:2 on the Well-Mild line, whereas the other generations split roughly 1:2. Plausible explanations for this difference, at the better end of the mental health range only, do not suggest themselves. In any case, this localized deviation is hardly sufficient to revise the comprehensive "no difference" judgment.

[18] As a corollary, the relationships of SES origin and age to mental health are negligibly altered when the generation variable is analytically controlled.

[19] Lerner, *op. cit.*, pp. 87–88.

[20] See the remarkable novel *Christ in Concrete* by Pietro Di Donato, 1937.

[21] U.S. Immigration and Naturalization Service, *Annual Reports.*

[22] Population of 500,000 or over.

[23] On the average, the sample's immigrants, when interviewed, had been in the United States about twenty-five years.

[24] P. Reymont, 1924.

[25] *The Ten Pains of Death*, 1959.

[26] The psychological processes that carry the individual toward considering and applying for emigration we shall hereafter refer to as *subjective selectivity*. The qualities distinguishing those accepted for migration (by the screening of external processes) from those rejected we shall refer to as *objective selectivity*.

Where we refer to selectivity without such specifications, we have in mind the special characteristics of migrants that are the *joint* consequences of both kinds of selection processes.

[27] W. S. Bernard, *American Immigration Policy*, 1950, p. 30.

[28] U.S. Department of Justice, *United States Immigration Laws*, M-50, rev. 1958, p. 2.

[29] For a travel visa to the U.S., the prosecutor's stance and guilty-until-proved-innocent attitude of American consulate personnel toward applicants has come to be epitomized abroad in the cryptic phrase: "Even Columbus couldn't get a visa." For those seeking an immigrant's visa "the bureaucratic barrier and curtain of red tape" are a far more forbidding gauntlet. How this gauntlet is experienced by refugees fleeing persecution has been poignantly conveyed in Menotti's stirring opera *The Consul.*

Any balanced reckoning of the effects of U.S. immigration laws and procedures must also take into account the sound human resources of immeasurable value that they have coincidentally denied to this country's development.

[30] In the years 1921 to 1940, some 4.6 million immigrants entered the country; in the same period 1.5 million departed, principally returnees to native lands.

[31] The literature based on investigations of mental hospital patients has offered discussion of the "drift theory." The latter is addressed to the finding that the institutionalized schizophrenic rate is highest in residential areas nearest the city's central business district (R. Faris and H. W. Dunham, *Mental Disorders in Urban Areas*, 1939). The theory assumes that such concentration is the result of movement into these sections of prodromal schizophrenics from other areas.

With group balances of Impairment and Wellness as our particular criterion, the data just presented suggest that U.S.-born migrants to Midtown on the whole are healthier in mental health composition than are the area's native New Yorkers.

This, of course, does not necessarily invalidate the drift theory as an explanation for the high mental *hospitalization* rates in core-of-city residential areas.

Focusing on the psychotics who are in-migrants and probably detached from kin, as compared with those who are natives of the city and are more likely to have protective kin nearby, it is a plausible hypothesis that the former, lacking such protection, are more likely than the natives to be surrendered to institutionalization. Here again, patient rates should be pointed not to questions of etiology, but rather to forces blocking or facilitating paths to different kinds of help.

[32] Rural-urban origin for all respondents was derived from replies to an interview

question about size of place where "you spent most of your childhood up to the age of 16."

[33] In the upper parental-SES class (A-B) the left-to-right urban-origin Sick-Well values are 44, 66, and 97, respectively. In the middle class (C-D), the corresponding values are 56, 84, and 130, respectively.

[34] By the latter criterion, a change from Boston to New York, i.e., from a smaller metropolis to a larger one, is minimal in magnitude, whereas removal from Roxborough (Vermont), to Boston, i.e., from a village to a metropolis, is a near maximal change.

[35] Sociologists have emphasized the significance of inter-community movements as an American phenomenon. In its general outlines this formulation is indebted to S. A. Stouffer, "Intervening Opportunities: A Theory Relating Mobility and Distance," *Am. Sociological Rev.*, vol. 5, no. 6, pp. 845–867, December, 1940; and A. M. Rose, "Distance of Migration and Socio-economic Status of Migrants," *Am. Sociological Rev.*, vol. 23, no. 4, pp. 420–423, August, 1958.

[36] B. Malzberg and E. S. Lee, *Migration and Mental Disease*, 1956.

[37] Here we shall not be at all concerned with the controversial issues centering on the relative merits and limitations of incidence (first admissions over a span of time) and prevalence (total patients at a given point of time) as alternative measures of patient frequency when applied to hospital populations (see Appendix C).

[38] Ornulv Odegaard, "Emigration and Insanity," *Acta Psychiat. Neurol.*, Suppl. 4, 1932. All citations here drawn from this work are as quoted in Dorothy S. Thomas's chapter in the SSRC monograph.

[39] The reference here is to the bed capacities of tax-supported hospitals in Minnesota and Norway.

[40] Goldhamer and Marshall refer to the " 'law of distance,' whereby the frequency of [mental-hospital] admissions tends to be inverse to the distance from a hospital." (H. Goldhamer and A. Marshall, *Psychosis and Civilization*, 1949, p. 63.) The element of spatial accessibility seems to uncover one of many possible considerations taken into account by the prospective patient and his family in deciding whether or not to accept hospitalization when both the need is indicated and the bed space is believed to be available.

[41] O. Odegaard, "A Statistical Investigation of the Incidence of Mental Disorder in Norway," *Psychiat. Quart.*, vol. 20, pp. 382–383, July, 1946.

[42] J. A. Clausen and M. R. Yarrow, "Paths to the Mental Hospital," *J. Social Issues*, vol. 11, no. 4, pp. 25–32, 1955.

[43] Malzberg and Lee, *op. cit.*, p. 47.

[44] *Ibid.*, p. 43.

[45] Not covered were patients in out-of-state private hospitals or patients at in-state municipal psychiatric hospitals offering short-term treatment.

[46] Cf. Malzberg and Lee, *op. cit.*, pp. 70–71.

[47] *Ibid.*, p. 45.

[48] *Ibid.*, p. 123.

[49] Bertram H. Roberts and Jerome K. Myers, "Religion, National Origin, Immigration and Mental Illness," *Am. J. Psychiat.*, vol. 110, p. 761, April, 1954.

[50] Of course, these occur largely beyond the age of 60, where adult immigrants are now far more concentrated than are the native-born.

[51] The sample's current patients encompass both clinic and office cases without differentiation between the two; but since a group's clinic rate is known from the Treatment Census, by subtraction of the latter rate an estimate of the office patient rate is possible. Two limitations beset these estimates: (1) Current patients among sample respondents may be a close but not exact equivalent of the one-day prevalence measure used in the Treatment Census; and (2) such estimates are always subject to sampling variance and therefore lack assurance of precision. Nonetheless, with due caution they can serve the purpose of filling a gap in our Treatment Census data.

[52] The latter, we can assume, follow the generation trend observed in the ambulatory current patients.

[53] This population is equally distributed among the six cells produced by trichotomizing respondents' own-socioeconomic-status range and dichotomizing the age range.

CHAPTER 15 *National-Origin Groups*

Thomas Langner and Leo Srole

Having probed the generation-in-U.S. levels for their connections with mental health, we can take the next step of examining the main national-origin or ethnic groups that subdivide Midtown's immigrant, second and third generations.

In the description of the Study area's population presented in Chapter 5, a number of key facts about these groups were indicated. Here we can enlarge the picture somewhat by sketching in several salient background details in space and time.

It will be remembered that in 1954 immigrants accounted for about one-third of Midtown's residents. According to the United States census, Germans and Irish were the two largest nationality segments of Midtown's immigrant population, comprising 21.7 and 16.9% of the latter, respectively.

Next in size within this generation (I) were people born in Czechoslovakia (9.2% of Midtown's immigrants), in Hungary (8%), in Italy (7%), and in the United Kingdom (6.9%). Among the still smaller groups were immigrants from Austria, who constitute 5.9% of the foreign-born population. Because they are few, they will be merged with the German group. There were also people from Poland, Russia, and Lithuania, who are predominantly Jewish and together add up to 5.6% of Midtown's immigrants. In view of their heterogeneity of national origin and small numbers, they are being held for separate analysis, with Jews of other nationalities, in the chapter on religious groups that follows.

Puerto Ricans, although few in the Study area, present special problems. On their home island they are citizens of the United States; therefore, on arrival in New York they are citizen in-migrants rather than alien immigrants. Nonetheless, sociological students of Puerto Ricans have observed: "As established by law, the Puerto Rican is an American, but the contrast between his rural island with its Spanish heritage and the American metropolis makes him in psychological and cultural reality a

foreigner in the city." [1] In this sense, we regard Puerto Ricans as an ethnic group differentiated on the same psychosocial plane as other nationality elements in the Study area. To judge from the Home Survey sample, Puerto Rico–born residents comprise about 4% of Midtown's generation I group in the age 20 to 59 range.[2]

Still unaccounted for by Census Bureau reckoning are people from many other countries abroad—each group too small to be handled statistically here. These "all others" plus Russians, Poles, and Lithuanians, with whom they are merged in this chapter, together add to about 25% of the age-inclusive Midtown immigrants.

By way of brief historical perspective, betwen 1910 and 1950 the total population of the Study area contracted about 15%. Seen in terms of the generations, the immigrants diminished in absolute numbers by one-third and the second generation by about 20%; whereas levels III and IV (not differentiated by the Census Bureau) actually expanded by nearly one-third. Also noteworthy is that between 1910 and 1950 the number of resident foreign-born from Germany, Austria, Ireland, Italy, Hungary, and Russia fell in each case by roughly one-half. On the other hand, in that period people from the United Kingdom increased by 12%, and those from all other countries combined multiplied by about four times. Populated once by a relatively small number of large nationality groups, the Midtown scene is now ethnically diversified to a far greater degree, i.e., characterized by a large number of smaller groups. When such a fractionated population must be studied in miniature cross section through a sample, analysis of ethnicity as a demographic variable presents refractory technical problems that we shall return to presently.

It is obvious that in focusing on the factor of national origin our interest is not in political entities per se. Historically, each immigrant-contributing nation-state had usually emerged from a people with an underlying communality in linguistic and other cultural traditions. Thus, nationality is a convenient, if rough, operational index of cultural differences within the broad tapestry of European civilization. Furthermore, at least for the larger of Midtown's ethnic groups, the element of common national background exerts a gravitational pull toward knitting local families into institutions and varying approximations of "community."

Social scientists are known to divide on several issues touching on the mental health implications of these national differences in what we shall call the immigrant's *ancestral culture*.[3] One view tends to see the ancestral culture as a single, more or less homogeneous whole, which is significantly different from the cultures of other European nations in two respects: (1) in the character of the built-in mechanisms that tend to generate stress—mechanisms seen as largely rooted in the culturally conditioned emotional economy of the several intrafamilial roles during childhood, and (2) in the nature of the culturally approved cathartic outlets for stress.

Relative to the ancestral cultures of the main ethnic groups represented in Midtown, there was no systematic knowledge available to us bearing on their differences in culturally patterned stress-generating and stress-ventilating mechanisms.[4] Furthermore, procurement of such knowledge was beyond reach of the methods employed in either the Home Survey or Treatment Census operations. An attempt to fill this gap was undertaken by more appropriate methods in a separate follow-up field investigation, designated as the Ethnic Family operation, which was the major responsibility of Marvin K. Opler during his six years as a member of the Midtown research team. The results of this operation will be reported in the third volume of the present monograph series.

The literature of psychology and common observation bear out the pronounced tendency of outsiders to characterize the members of a minority group in stereotyped terms. The common-stamp attribution takes a more sophisticated form among those students who seem to assume a given people to be essentially homogeneous in their most significant cultural features.[5]

Relative sociocultural homogeneity within an ethnic group is an empirical issue that cannot be swept under the research carpet in the guise of a self-validating axiom. To be sure, this would make for seemingly tidy convenience in the research operation, but it also delays the day of full reckoning.

The Midtown ethnic groups revealed in our sample population are excellent cases in point. Approximations of complete homogeneity, at least in the sphere of religious origin, are found among local Italians[6] and Irish, who are 95% of Catholic background, and among Puerto Ricans, who are 89% Catholic. On the other hand, the ratio of Catholics to Protestants to Jews among Hungarians is roughly 6:1:3 and among German-Austrians 4:4:2.

The closest approximation to homogeneity in educational background is traced to the sample Puerto Ricans, 70% of whom did not go beyond primary school, and only 4% reached college. At the other extreme, in Midtown's sample British group[7] the corresponding proportions are 27 and 36%, respectively.

Or, consider generation composition itself. In the Midtown sample, representation of generation I ranges from 85% of the Puerto Ricans and 61% of the Hungarians to only 28% among Italians. Conversely, few or no generation III people appear among sample Puerto Ricans and Hungarians, in contrast with 33% among both Irish and British and 20% among German-Austrians.

The generation III element is itself interesting, if we dichotomize it into (1) those whose four grandparents were of like transoceanic national origin and (2) those whose grandparents were of two or more different national backgrounds, Old American included. The ratio of

people in these two subgroups is about 1:2 among both Irish and German-Austrians and 1:9 among the British third generation. If the criterion is intermixing of nationality stocks, the American melting pot is here seen in full operation.[8]

If we narrow the focus to the immigrant segment in each nationality group, we find important intergroup demographic differences bearing on mental morbidity rates. For example, sample generation I Germans show only 12% of their members to be in the 20 to 39 age range, whereas of Puerto Rican immigrants fully 75% are in that age bracket. In other ethnic groups, the immigrants are more evenly balanced in age distribution.

Among the several groups of immigrants we also find differences in SES origin, i.e., parental socioeconomic status. It will be remembered that the sample's range in parental socioeconomic distribution, when its analytical control becomes necessary, is cut into three equally populated categories, designated low, middle, and high. On this criterion, generation I Irish, Italians, and Czechs are each predominantly (over 50%) from low-SES families; whereas German-Austrian, British, and Hungarian immigrants are in each instance more heavily derived from middle-SES parents. Of these two sets of immigrant groups, the Irish, Italians, and Czechs were in greater numbers drawn from farm, village, or town communities and the German-Austrians, British, and Hungarians from more urbanized places.

Speaking of immigrant groups in America generally, Mills, Senior, and Goldsen[9] observe that each "is accused of 'clannishness.' Yet the immigrant group itself is almost never cohesive, but is criss-crossed by economic cleavages, intervillage rivalries, rural-urban lines, and sometimes by religious differences, educational rank, and vocation. But if the group as a whole has one visibly distinguishing characteristic, it is that all members are usually lumped together by the 'natives.' "

GROUP ATTACHMENTS

One concern of the writers in designing the Study was to take the question of relative cohesiveness within ethnic groups out of the realm of impression and onto an empirical footing for comparative analysis. Stereotypes aside, one can uncritically observe the impressive institutional apparatus of a given ethnic group on the metropolitan scene and conclude that it is a broadly based, effectively functioning community, with its people rocklike in their attachment to their nationality origins and traditions. Yet more complete investigation might well reveal facts of a different nature.

To meet this empirical problem in the context of the Home Survey interviews, an operational scale was devised according to which one could measure an individual's relative behavioral attachment to or detach-

ment from his national traditions, his country of origin, and his local ethnic group. The scale consisted of a sampling of five component indicators: (1) whether or not the individual prefers his native culinary tradition; (2) whether or not he observes native secular or religious holidays, e.g., St. Patrick's day among the Irish; (3) whether or not he retains any interest in the "old country"; (4) whether or not he participates in the secular affairs of his local ethnic group; and (5) whether or not he is opposed to young people marrying out from his nationality group.

The interview questions constructed to represent these components were uniformly worded for all groups, adapted only to refer to the specific national origin of the respondent. As read, for example, to generation I, II, and III respondents of Italian descent, the questions were as follows:

1. Comparing Italian style cooking and regular American style cooking, do you like Italian style cooking (*a*) better, (*b*) just as much, or (*c*) not as much?
2. During the last year or so did you do anything at all special about *any* of the Italian holidays?
3. Are you interested at all in what's going on today in Italy?
4. Do you attend Italian-American meetings or social affairs often, occasionally, or not at all?
5. Some Italian parents feel that it is all right if a son or daughter wants to marry someone who is not Italian. Other Italian parents don't feel that way at all. How do you feel about it: is it all right or *not* all right?

Each respondent was scored from 0 to 5 according to the number of yes or "attached" replies he gave. For convenience in reporting, we will here designate respondents as *attached* if their score was 2 to 5 and *detached* if the score was either 0 or 1.[10]

The nationality attachment-detachment scale was devised in order to compare the several ethnic populations in the sample according to extent of group cohesion within each. If the scale *actually* measures what was intended, differences must appear among the generation-in-U.S. levels in only one possible direction, namely, most attachment in generation I and least in generation III. Moreover, within generation I greatest attachment must appear among those who arrived in this country as mature adults (age over 25) and least attachment among those who arrived as children (age 17 or under). The line-up of attached and detached, classified as indicated above, in the several inclusive generation segments is seen in Table 15-1.

The differences in attachment rates fall into the rank order expected by our formulation.[11] With this internal evidence as a form of validation for the scale, we can determine its results when applied first to the immigrant segment (generation I) in each of the seven ethnic groups presented in Table 15-2 below.

Table 15-1. *Home Survey Sample* (Age 20–59), Nationality Attachment-Detachment Rates by Generation Level

Generation level	Attached	Detached	Total
Generation I arrived as:			
Mature adults (over 24)	51.1%	48.9%	100%
Young adults (18–24)	41.4	58.6	100
Children (under 18)	33.4	66.6	100
Generation I: Total	43.2	56.8	100
Generation II: Total	23.8	76.2	100
Generation III: Total	16.7	83.3	100

The number of cases in several of these immigrant groups is small. This suggests caution against drawing inferences from small differences and also prevents control for other relevant factors, namely, age at immigration, sex, years in the United States, etc. Nonetheless, we can take note that in general the lowest attachment rates are found among the British and German-Austrian immigrants, the only two ethnic groups that are in combination (1) West European (2) predominantly Protestant,[12] and (3) more heavily of urban than of rural origin. Substantially higher in attachment rates are the Czechoslovakian and Hungarian immigrants, who of course are (1) East European in language stock, (2) predominantly Catholic,[13] and (3) in the former group, at least, predominantly rural in origin.

The highest attachment frequency is found among the Puerto Ricans, probably in part a function of a circumstance that does not apply to any of the other groups; namely, they are of very recent arrival compared to the average of twenty-three years of residence in this country for generation I as a whole.

With the Puerto Ricans seemingly a special case, the immigrant groups in Table 15-2 rank themselves according to their nationality detachment rates in an order roughly corresponding to the degree of sociocultural congruity between their backgrounds and the basically Anglo-Saxon,

Table 15-2. *Home Survey Sample* (Age 20–59), Attachment-Detachment Rates in Generation I by Ethnic Group

Ethnic group	Attached	Detached	N = 100%
Puerto Ricans	65.1%	34.9%	(23)
Czechoslovakians	53.3	46.7	(60)
Hungarians	53.3	46.7	(45)
Irish	46.8	53.2	(79)
Italians	43.5	56.5	(40)
German-Austrians	34.7	65.3	(164)
British	27.0	73.0	(37)

urban, industrial, and Protestant trends that are the dominant figures in the cultural fabric of contemporary America.

Since nationality detachment can be taken as an indicator of deculturation, and although deculturation from the old society and acculturation to the new do not necessarily move in a 1:1 relationship, we can find in Table 15-2 confirmation for a generalization advanced in an earlier study,[14] that intergroup differences in acculturation tempo of immigrants depend in part on the degree of native sociocultural congruity with salient aspects of the American environment.[15]

Remaining open is the question whether the data for the generation II segments of the several ethnic groups will also fit the culture congruency postulate. In Table 15-3 we present their detachment frequencies only, alongside the corresponding rates for each group's immigrant generation. Appearing with only four generation II people in the sample, the Puerto Ricans cannot be represented in the table.

Table 15-3. *Home Survey Sample* (Age 20–59), Detachment Rates in Generations II and I by Ethnic Group

Ethnic group	Generation II	N = 100%	Generation I	N = 100%
Czechoslovakians	75.9%	(54)	46.7%	(60)
Hungarians	69.3	(26)	46.7	(45)
Irish	74.0	(92)	53.2	(79)
Italians	74.2	(93)	56.5	(40)
German-Austrians	84.4	(109)	65.3	(164)
British	84.4	(32)	73.0	(37)
Total for generation	76.2		56.8	

Of course, in the generation II column, the range of differences quantitatively possible for the detachment rates is far narrower than among the immigrants. Nonetheless, we see that British and German-Austrians again stand out with high rates among their generation II peers. In this particular sense, we can discern that the factor of cultural congruence continues to be reflected in the deculturation-acculturation tempo of generation II ethnic groups, although with considerably diminished magnitude.

The above discussion has been intended to illuminate, however briefly, something of the intragroup heterogeneity in most Midtown nationality segments and the intergroup differences in tempo of transformation from the old-country to the new-American model of man.

From the specifically Italian, or German, or Irish line of ancestral culture, for example, there was no ground for framing hypotheses relating to the expected mental health composition of corresponding nationality groups in the Midtown sample—especially as these ancestral cultures

were all kindred variants of the millennial-old European civilization. Nevertheless, recommending itself was the criterion of relative congruity between the several ancestral cultures in their major contours and the over-all cultural fabric of urban America. Accordingly, one of the early hypotheses entertained by the Midtown research team was this: The greater the degree of such congruity among local ethnic groups, the less would be the adaptive stresses and the better correspondingly would be the resulting mental health. An alternative hypothesis was also proposed: The faster the tempo of change among ethnic groups, with respect to shifting attachments from the old to the new cultural foundations, the greater the strain and the less propitious the mental health consequences. Under the "congruity" hypothesis, the British and German-Austrian groups, by way of illustration, would expectedly turn up with the most favorable mental health composition. Under the "tempo" hypothesis, on the other hand, these two groups would foreseeably present the least favorable mental health picture. How the data fall between these two alternatives is the question examined in the next section of this chapter.

HOME SURVEY SAMPLE: MENTAL HEALTH DISTRIBUTIONS

The ethnic factor is not unknown to studies in medical epidemiology. Among nationality groups resident in the United States, mortality differences have been found for such causes of death as pneumonia, tuberculosis, diabetes, and heart disease.[16] Also reported among these groups are differences in the frequency of cancer at particular sites.[17]

Previous investigations that focused on nationality background and its relation to mental illness have been exceedingly few in number. The only one known to us that employed a general population is that of Hyde and Chisholm.[18] This study involved 60,000 consecutive selectees from homes in eastern Massachusetts, who were examined in 1941–1942 at the Boston Induction Station. The criterion was rejection for psychiatric reasons. As reported, the rejection rates for three nationality groups also covered in the Midtown Study were:

	Italian	Irish	Old American
Per cent rejected	13.7	12.8	5.7
Per cent accepted	86.3	87.2	94.3
N = 100%	(3,472)	(2,440)	(1,640)

Hyde and Chisholm indicate that the Old-American men were from communities[19] that were graded on the whole as high (B) in socio-economic level, whereas the Italians and Irish were from communities rated as low in SES (E and F, respectively). The authors provide this

information so that "corrections can be made for [nationality] differences that may be traceable to [SES]." Although they do not make such corrections, they report elsewhere that over-all rejection rates for communities of B,E, and F socioeconomic levels are 9.2, 12.7, and 16.6%, respectively. In the light of the latter, it appears offhand that if SES differences could be standardized, the Irish would have the highest rejection rate by a small margin and the Old American the lowest rate by a smaller margin than that reported. However, there are reasons for viewing these findings with serious reservations.[20]

We must now turn to the seven nationality groups represented in the Midtown sample population. For the record, we are presenting in Table 15-4 the distribution of each group on the psychiatrists' classification of mental health. Covered in each group are its three generation segments, I, II, and III.

Table 15-4. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Nationality Origin (Generations I, II, III combined)

Nationality groups	Mental health categories							
	Well	Mild symptom formation	Moderate symptom formation	Impaired	Marked* symptom formation	Severe* symptom formation	Incapacitated*	N = 100%
British	22.0	33.0	15.0	30.0	17.0	9.0	4.0	(100)
German-Austrians	18.6	37.3	21.0	23.1	11.2	9.5	2.4	(338)
Irish	17.5	33.4	27.2	21.9	12.6	7.3	2.0	(246)
Italians	14.0	34.2	24.5	27.3	15.4	9.8	2.1	(143)
Hungarians	13.5	35.1	24.3	27.1	20.3	4.1	2.7	(74)
Czechoslovakians	10.5	41.1	21.0	27.4	12.9	9.7	4.8	(124)
Puerto Ricans	3.7	44.5	7.4	44.4	18.5	25.9	0.0	(27)
All others	18.8	39.4	20.4	21.4	14.1	4.4	2.9	(382)
Old Americans (Generation IV)	28.0	32.0	22.2	17.8	9.3	5.8	2.7	(226)
Sample total	18.5%	36.3%	21.8%	23.4%	13.2%	7.5%	2.7%	(1,660)

* These values are subtotals of the Impaired figure.

A first consideration is that if different national backgrounds exert varying impacts on mental health, they must manifest this power most clearly among people born in and shaped by these overseas societies, i.e., among the immigrant element in the several ethnic groups.

In the light of this overriding consideration, we have no choice except to narrow our comparison directly to the ethnic groupings within the immigrant generation. Although left with relatively few people in these groups, we accept the sacrifice of statistical viability in the interest of substantive insights suggested, if any.

In Table 15-5 the several identified immigrant groups are arranged in the order of diminishing detachment frequencies as previously seen in

Table 15-5. *Home Survey Sample* (Age 20–59), Distributions on Mental Health Classification of Immigrant Respondents (Generation I) by Nationality Groups

Nationality groups	Mental health categories				
	Well	Mild symptom formation	Moderate symptom formation	Impaired	N = 100%
Total generation I	16.1%	36.0%	21.2%	26.7%	(593)
British	21.6	39.7	19.0	29.7	(37)
German-Austrians	18.3	32.9	24.4	24.4	(164)
Irish	12.5	35.0	22.5	30.0	(79)
Italians	15.0	32.5	15.0	37.5	(40)
Hungarians	13.6	36.4	31.8	18.2	(45)
Czechoslovakians	13.3	41.7	18.3	26.7	(60)
Puerto Ricans	0.0	39.1	8.7	52.2	(23)
All others	19.2	39.7	19.2	21.9	(145)

Table 15-2 of this chapter. It is first observed that the British and German-Austrians, who stood highest on the detachment scale, here have the largest Well rates; whereas the most strongly attached group, the Puerto Ricans, are altogether absent from the Well ranks. Seemingly intimated here is the existence of some sort of relationship between ethnic detachment and wellness.

Beyond the category of the Well, however, there seems to be no consistent connection between mental health composition and rank order of detachment from the national-origin group. This applies to the Impaired rates as well as to frequencies of the Moderate and Mild categories of symptom formation. On the whole, therefore, these data from Midtown's immigrant generation fail to lend support to either the congruity or the tempo hypotheses defined above.

Hypotheses aside, our attention is drawn to three groups that stand out as potential deviants in this population of immigrants. We note impairment rates of 37.5 and 18.2% among the Italian and Hungarian immigrants, with an accompanying reversal in their Moderate category frequencies, i.e., 15.0 and 31.8%, respectively. Before interpreting these divergences as reflecting unspecified national differences in the culture patterns of Italy and Hungary, a specifiable fact must first be taken into account.

It will be recalled that the sample respondents were stratified by socioeconomic status of parents, with the sample's distribution of parental-SES scores divided, when their analytical control was necessary, into three more or less equally populated SES-origin groups. We know that there is a link between parental SES, so classified, and the Impaired-Well mental

health ratio and that the link has survived our efforts to shake out possible spurious effects of other demographic variables.

How the populations of Italy and Hungary, at the time our respondents departed these lands, would have distributed themselves on this SES-origin continuum is of course unknown to us. But we do know how *these* foreign-born respondents were distributed:

Parental SES	Generation I	
	Italians	Hungarians
Lower (E–F)	50.0%	22.2%
Middle (C–D)	32.5	48.9
Upper (A–B)	17.5	28.9
N = 100%	(40)	(45)

The number of people in each ethnic group is too small to permit control of these SES-origin differences by standardization. But knowing that the lower stratum contributes disproportionately to the Impaired category of mental health, we can be sure that were such standardization possible the effect would be to substantially narrow the 2:1 divergence in impairment rates seen between Italian and Hungarian immigrants. Similarly, in place of origin the Italians are predominantly rural and the Hungarians more largely urban. In short, the above divergence in morbidity rates principally reflects the facts that the Italians are mainly type O immigrants and the Hungarians type N. It will be remembered that for *all* type O and type N immigrants in the Midtown sample, the morbidity rates were 34.3 and 18.5%, respectively.

The third group warranting special attention in Table 15-5 are the Puerto Rican immigrants, half (52.2%) of whom appear in the Impaired ranks—or double the rate (26.7%) for generation I as a whole—a difference appearing to be statistically significant at the .01 level of confidence. With an average age of 35, these Puerto Ricans are eleven years younger, on the average, than the sample generation I as a whole. About half of them qualify as type O immigrants. Only a few are type N. The remainder are of low parental SES and town-city origin and seem to define an "urban proletariat" type, which is relatively rare in our sample of immigrants.

Testing the assumption that the current poverty of these Puerto Ricans might be a specific source of stress contributing to their deviant mental health picture, we isolated a subsample of 252 European immigrants with family incomes identical to that of the 18 Puerto Ricans in the lowest income bracket. The morbidity rate of the former aggregate was just half (31%) that of the latter (61%).

Compared to other immigrants, who found in Midtown a main residential concentration and institutional center for their fellow nationals, the Puerto Ricans in the Study area are, geographically speaking, isolated outriders from the main body of their fellow islanders gathered elsewhere in New York City.[21] We do not know whether subjective selection factors related to mental health have operated to determine this residential self-separation from their cultural group.

Differential selection may also be involved for Puerto Rican immigrants generally. As indicated in the previous chapter, alien immigrants, before receiving an American visa, must pass the screen of Federal statutes "barring mentally, physically and morally undesirable classes and persons likely to become a public charge." [22] Compared with this severe kind of governmental screening, the Puerto Ricans, as citizen in-migrants, are limited only by the same kinds of spontaneous self-selection as are migrants to New York from the other 49 states. The variable sifting effects on the characteristics of the two forms of migratory movements also remain unknown.

Nor can events in Puerto Rico itself be overlooked. That island has rapidly moved from an agrarian to an urban, industrial stage of development. We are not yet informed whether such movement has there had the same unsettling psychological consequences as have been reported from other fast-changing agrarian areas.

Finally, and of particular importance for appropriate perspective, is the fact that the Puerto Ricans in New York are recent arrivals from their home island. They betray signs of the initial, transient stage of uprooted instability that marked most previous nationality groups in the decades immediately following their settlement here.

Although Puerto Ricans in the Midtown sample are few in number, they give us a brief glimpse into an extremely complicated tangle of factors. This complex of exogenous sociocultural forces and pressures, converging with endogenous selection processes, may create turbulent effects overtly visible in the problems of the City's Puerto Rican people. It is hoped that specifically focused research might soon answer these speculations.

In the previous chapter we found little difference between generations I, II, and III in their mental morbidity rates. When we now compare generation levels within each ethnic group, generation III is represented by sufficient individuals only among the British, German-Austrians, and Irish, and their mental health distributions are uniformly like that of their generation II juniors in the same nationality group. This likewise applies when generations II and I are compared in the British, German-Austrian, and Czech groups. However, we must report that this is not the case among the Irish, Italians, and Hungarians whose mental health distributions are presented below:

Mental health categories	Irish		Italians	
	Generation I	Generation II	Generation I	Generation II
Well	12.5%	18.6%	15.0%	15.1%
Mild symptom formation	35.0	37.4	32.5	35.3
Moderate symptom formation	22.5	27.5	15.0	27.0
Impaired	30.0	16.5	37.5	22.6
N = 100%	(79)	(92)	(40)	(93)

Here we see that in both the Irish and Italian groups the immigrants have impairment rates significantly higher than those of the second generation. However, there are intergeneration age and SES-origin differences in each ethnic group. Standardization for these differences is not possible among the Italians[23] but is possible among the Irish, where we shall now merge generations II and III. The Irish mental health distributions, so standardized, are as follows:

Mental health categories	Irish	
	Generation I	Generations II–III
Well	11.2%	18.0%
Mild	35.6	35.2
Moderate	24.5	26.4
Impaired	28.7	20.4
N = 100%	(79)	(167)

Standardization among the Irish has reduced the intergeneration difference in impairment rates to a margin no longer statistically significant. Were such standardization possible among the Italians, there is reason to believe that the remaining generation difference would also fall below the level of statistical acceptability.

We have noted that the Hungarians also appeared to be an exceptional group. The sense of this judgment can be gathered from the mental health composition of their two generation segments:

Mental health categories	Hungarians	
	Generation I	Generation II
Well	13.6%	14.8%
Mild	36.4	29.6
Moderate	31.8	14.8
Impaired	18.2	40.8
N = 100%	(45)	(26)

Here the Hungarians emerge as seeming anomalies in that the higher impairment rate for the first time is found not among the immigrants, as hypothesized, but among their second generation juniors. Standardization for SES origin and age composition is here altogether ruled out by their small numbers. Nonetheless, the picture becomes clearer if we look into the parental SES of the two generations of Hungarians:

Parental SES	Hungarians	
	Generation I	Generation II
Lower (E–F)	22.2%	46.2%
Middle (C–D)	48.9	46.2
Upper (A–B)	28.9	7.6
N = 100%	(45)	(26)

The seeming anomaly is here seen reduced to this fact: Hungarian generation II has a representation in the low SES-origin stratum which is double that of their Hungarian immigrant neighbors. Thus, if it were feasible to standardize for parental SES, the Hungarian intergeneration divergence in impairment rates would probably be largely eliminated.

We conclude that in no national group are there intergeneration divergences in mental health composition that cannot be traced to the operation of SES origin and age differences.

PATIENT FINDINGS

In previous chapters, the number of Midtown's psychiatric patients were reported from two field operations. From neither of these operations do the patient data on the Midtown nationality groups permit presentation here.

It is clear that variations in treatment rates can be attributed to differences in ethnic background only if analytical controls can be applied to disentangle other, more fully documented, demographic factors like age, SES origin, and generation-in-U.S. For purposes of the Midtown Treatment Census operation, the U.S. Census Bureau does not provide total population figures for subgroups analytically refined in this multifactorial fashion.

The Midtown Home Survey, in dealing with what is called the patient-history variable among its sample respondents, is not dependent on Census Bureau figures. Its patient rates have consistently been calculated relative to the Impaired mental health category only in a specific demographic group or subgroup. However, the grand total of generation I to III individuals in the several mental health categories is relatively small

among most ethnic groups isolated in our sample population. This is especially the case in the Impaired category.[24]

It is not only that the distribution on the patient-history variable of each of these Impaired subgroups is statistically unreliable. It is rather that this unreliability is only one in a related series of considerations; e.g., we know that ever-patients are more numerous among the Impaired who are (1) younger (under age 40), (2) of higher socioeconomic status, and (3) American-born. Since the ethnic Impaired segments are too small to permit analytical control for these factors, differences in their ever-patient rates would be decidedly ambiguous, even as clues to the substantive connection between ethnic background and quest for therapy. Given Midtown's population scatter through many relatively small ethnic groups, the size of our sample automatically excludes analyses of such extreme complexity.

SUMMARY

In this attempt to test the factor of national origin, we first confined ourselves to a comparison of seven ethnic groupings within the immigrant generation. With the mental health composition of generation I *in toto* serving as yardstick, we found that four ethnic groups conformed quite closely in their mental health distributions. Relative to this norm, however, the Italian-born were higher in impairment rates, and the Hungarian-born were lower—a difference exposed as largely a product of the fact that the former were more heavily type O immigrants and the latter were predominantly type N. Most deviant of all in apparent concentration of mental morbidity were the immigrant Puerto Ricans, and consideration was given to the special factors that may be operating in New York City's newest in a long procession of nationality groups.

As second step, we directed attention to intergeneration differences in mental health within six ethnic groups. In only three of these groups were such differences found. However, were control of their accompanying divergences in SES origin and age possible, these differences would very largely disappear.

This chapter sought to trace variations in mental health composition to a factor that looms large on the Midtown scene, namely, respondent differences in national culture derivations. We could discover no firm discrete variations of this kind. Whether or not other studies will confirm this finding is an entirely open question, needless to say.[25]

We would suggest that the question can be carried to the next stage of advance only if each ethnic group subsample is large enough to permit control for the obscuring effects of more powerful demographic factors. Even so, to test definitively for the links between international differences in culture and mental health, investigations will have to move to a more

appropriate site than the American metropolis, namely, to the indigenous populations in the countries of origin. Among immigrants to America alone, there are too many special complications, such as subjective and objective selection, variable age at migration, familial structure in migration, differential experiences upon arrival, stage of development in the local ethnic community—as a stabilizing or disruptive influence—and stage in familial Americanization. All these intervene to becloud observation of the unencumbered factor of national culture differences and their eugenic-pathogenic potentials for mental health.

The writers now entertain the hypothesis that unencumbered observation will *not* reveal significant international differences in these eugenic-pathogenic potentials within the European continent west of the iron curtain. This does not blink the cultural differences existing among the countries of this continent. This *does* reflect some skepticism about the relative weight of these differences as against two other sets of likenesses that these countries share. One overarching source of likeness is their common roots in the general 2,000-year-old European-Christian tradition. In the next chapter we shall see whether the Catholic-Protestant split in the American version of that tradition registers on the mental health criterion of concern to us here.

A more specific source of intraEuropean likeness is the basic socio-economic similarity. With corresponding SES groups in different countries apparently go similar conditions of life, values, attitudes, and behavior patterns. In this perspective, upper-class people from different countries, conspicuously joined in the "international set," probably have more in common with each other than does each national segment of that set with co-nationals in the lower reaches of the social class range. In turn, we suggest that the lower classes in the several countries, except on the point of language, have more that culturally binds than divides them. The same probably holds for the middle classes as well.

In fine, we hypothesize as follows: Comparative studies of indigenous European populations will yield conclusive findings that do not grossly diverge, in general trend, from the necessarily inconclusive comparative data for Midtown's immigrants of the several national backgrounds here represented.

It is relevant to add in closing that within the circumscribed framework of Midtown's immigrants and their European nationality subgroups, we can test a key assumption underlying the quota differences that were frozen into law by the congressional immigration acts of 1921 and 1924. This was the assumption that immigrants from Western and Central European countries were preferable to those who might originate in the Southern and Eastern sections of the Continent. If mental health of immigrants (of like SES origin and rural-urban origin) is still a meaningful index of desirability in the eyes of America's policy makers (as it was

in 1921–1924), then the Midtown data plainly appear to contradict that assumption.

FOOTNOTES

[1] C. Wright Mills, Clarence Senior, and Rose K. Goldsen, *The Puerto Rican Journey*, 1950, p. 79.

[2] Or, 1.2% of the total Midtown population. However, Puerto Ricans do not figure in the Census Bureau's count of immigrants.

[3] By this term we mean the complex system of more or less persisting, sanctioned folkways in which immigrants from a given country were bred during the childhood years prior to departure for the United States.

[4] As a result, there was no basis for hypothesizing the degree and direction of differences in mental pathology risk that might be expected in these groups.

[5] See A. R. Lindesmith and A. L. Strauss, "A Critique of Culture-Personality Writings," *Am. Sociological Rev.*, vol. 15, no. 5, pp. 587–600, October, 1950, in particular the section entitled "Oversimplification and the Homogeneity Postulate." Also, A. Inkeles and D. J. Levinson, "National Character: The Study of Modal Personality and Sociocultural Systems," in G. Lindsey (ed.), *Handbook of Social Psychology*, 1954, pp. 971–1020.

[6] Unless otherwise specified, data on a particular ethnic group here refer to its three generation levels inclusively, i.e., I, II, and III.

[7] This group includes immigrants and generation II and III descendants of immigrants from England, Scotland, and Wales.

[8] If the mixed-III respondent's grandparents were of only one foreign nationality—and if he had one or more American grandparents—he was automatically classified under the former. If his grandparents were of *different* overseas nationalities, he was asked which he himself feels "closer to." He was then classified under the group he named.

[9] Mills, Senior, and Goldsen, *op. cit.*, p. 82.

[10] Replies to question 5 above were found in all ethnic groups to be "all right" by such overwhelming consensus as to be of doubtful discriminative value. For all practical purposes, therefore, most respondents with a score of 1 had given "detached" replies to all four of the items preceding 5. Stated differently, a respondent classified as attached gave an affirming reply to at least one of the first four items.

[11] It might be added that among the generation I adult arrivers the frequency of detached individuals is considerably larger than we had anticipated.

[12] Specifically, 79% of the British and 44% of the German-Austrians are of Protestant origin.

[13] Specifically, 57% of the Hungarians and 73% of the Czechoslovakians are of Catholic origin.

[14] W. L. Warner and L. Srole, *Social Systems of American Ethnic Groups*, 1945.

[15] See also R. T. Berthoff, *British Immigrants in Industrial America: 1790–1950*, 1953. This valuable work by a historian focuses most heavily on the second half of the nineteenth century. Comparisons with immigrants of other nationalities are drawn throughout. Special emphasis is placed on the relative ease of the British in fitting into and advancing in the American society. The importance of intercultural congruence is indicated in these observations: "In practically every American field which they entered, the British enjoyed the highest status and rose most easily. . . . With folkways and habits of thought acceptable to Americans, they enjoyed a unique advantage over most newcomers . . . the new country must have seemed rather like the old . . . settled among the Americans, [they] passed almost unnoticed. They hardly seemed to be 'immigrants' in the usual condescending sense of the word [pp. 122–132]."

The second, and perhaps more striking theme of this work is that British immigrants were accepted by Americans "as equals . . . yet they too clung to old loyalties . . . few doubted that for a proper life the old country was, after all, the only land [pp. 139–142]."

[16] M. Calabresi, "The Relation of Country of Origin to Mortality for Various Causes in New York State," *Human Biol.*, vol. 17, pp. 340–365, 1945.

[17] M. E. Patno, "Geographic Study of Cancer Prevalence within an Urban Population," *Public Health Repts. (U.S.)*, vol. 69, pp. 705–715, August, 1954.

[18] R. W. Hyde and R. M. Chisholm, "The Relation of Mental Disorders to Race and Nationality," *New Eng. J. Med.*, vol. 231, no. 18, pp. 612–618, November, 1944.

[19] That is, Selective Service Board areas.

[20] A damaging limitation appears in this particular substantive phase of the Boston Induction Station studies directed by Hyde. By way of example, the 12.8% rejection rate reported for the Irish refer not to all Irishmen in the sample, but to all men from "Irish communities," defined as Selective Service Board districts whose selectees were in the majority Irishmen. Counted, therefore, as "Irish" were non-Irish men living in such predominantly Irish communities, and excluded were all Irish selectees who did not reside in such districts.

The extent of this exclusion may be judged from the fact that the selectees living in these Irish districts totaled 2,440, or only 4% of the 60,000 men from the heavily Irish region of Boston.

Compounding the difficulty is the fact that we are not told how those counted as actually Irish in the Irish districts were determined. Were they of Erinbirth only? Or did they also include the U.S.-born of Irish descent?

The root difficulty is inherited from the tradition of ecological studies—here uncritically applied—where individuals living in an area are classfied not according to their own characteristics but according to the average or predominant characteristics in the over-all population of the area.

[21] Mr. Joseph Suarez, of the Albert Einstein College of Medicine, and a lifelong observer of New York's Puerto Ricans, in personal communication has commented on the significance of this point. He calls attention to a powerful institution that generally tends to keep New York Puerto Ricans dependently chained to their areas of residential concentration. This is their neighborhood grocery store, which on the one hand carries indigenous Puerto Rican staples and on the other hand extends credit to fellow immigrants whenever need arises.

Thus, in leaving the areas of high Puerto Rican density, the Midtown Puerto Ricans have removed themselves from ready access to these two important services.

[22] W. S. Bernard, *American Immigration Policy: A Reappraisal*, 1950, pp. 23–24.

[23] Because of insufficient cases of Italian immigrants.

[24] For example, there are 12 among all Puerto Rican respondents, 20 among Hungarians, 30 among the British, 34 among Czechs, 39 among Italians. Even the Irish and German-Austrian impairment cases do not exceed 54 and 78, respectively.

[25] This finding on the Study psychiatrists' classification of degree of symptom formation and functional disability would not be controverted by a finding of qualitative differences among nationality groups in syndromal patterns.

CHAPTER 16 *Religious Origin*

Leo Srole and Thomas Langner

In the antiphony of voices that express American society, Protestantism, Catholicism, and Judaism stand out as the nation's three great religious communions. In the hypersegmented, centrifugal social structure of Manhattan, these perform a special and generally overlooked function, as the editors of *Fortune* magazine have perceptively observed:[1]

> So what gives New York its coherence? No city could exist for three hundred and thirty-odd years in incoherence. For one thing, surprisingly enough, it hangs together on the cord of its religions. . . . From its religions the city derives much strength and character. Protestantism's vigorous social ethic, with which the city began, is still a force in New York as throughout the nation. . . . Quite apart from the fact that Jewish intellectuality and artistic appreciation give the city a special élan, Jewish philanthropy, with its deep religious base, lifts the level of the whole community. The emergence of Catholics to higher levels in the city's social structure . . . brings to New York's amalgam the ancient firmness and cultural richness of that church. For all their differences, these three faiths are united in the conviction that the community exists to serve men.

The significance for mental health of personal roots in these different religious traditions[2] is the complicated and difficult question that shall engage us in this chapter.[3]

TREATMENT CENSUS FINDINGS

Due note should first be taken of the meager research literature that bears on the above question. Until recently, such research has been confined to patients of state mental hospitals, classified by religion as inscribed on the case record. Such studies have usually categorized patients only in terms of the Jewish, non-Jewish dichotomy.[4]

Nevertheless, from the largest of these investigations, Malzberg[5] concludes: "On the basis of the estimated population in 1950, Jews had a

rate of first admissions [to New York state-supported mental hospitals] of 74 per 100,000 population compared with 102 for white non-Jews. As regards the severe mental disorders which result in hospitalization, it is therefore clear that Jews have a lower rate than non-Jews. This confirms a similar conclusion which was arrived at in three separate studies."

The New Haven study signaled a considerable advance beyond the foregoing literature in that it covered one-day prevalence of patients in *all* treatment sites and also differentiated Protestants and Catholics. On the basis of published New Haven distribution data,[6] we have calculated the rates per 100,000 estimated population among the several New Haven religious groups as presented in Table 16-1.

Table 16-1. *New Haven Psychiatric Census* (Age Inclusive), Diagnostic Composition (Prevalence Rates per 100,000 Population) of New Haven Patients by Religious Affiliation*

	Catholic	Protestant	Jewish
Neuroses and character disorders	140	158	442
Alcohol and drug addictions	45	36	0
Psychoses and affective disorders	481	414	496
Organic disorders	120	136	68
Total Patients Rate	786	744	1,006

* Adapted from B. H. Roberts and J. K. Myers, "Religion, National Origin, Immigration, and Mental Illness," *Am. J. Psychiat.*, vol. 110, no. 10, p. 760, April, 1954.

In rates of *treated* psychoses and related disorders we note only minor differences among New Haven's three religious groups.[7] This is a finding at variance with previous studies of state hospital patients.[8] On the other hand, if New Haven Protestants and Catholics are also alike in frequencies of *treated* neuroses and character disorders, Jews stand out in this category with an appreciably higher patient rate.

In certain technical aspects, the New Haven study to date has had its only counterpart in the Midtown Treatment Census operation. As in New Haven's case, the latter had no United States census data on the religious composition of the Midtown population. However, from the religious distribution of the Home Survey sample we could estimate such composition, at least in the age 20 to 59 segment of the Midtown population. In addition to this intercommunity difference in the age span of the religious group rates, the one-day prevalence counts of patients in Midtown and New Haven diverge in two other respects: (1) Midtown's hospital enumeration excluded patients continuously hospitalized for five years or more, whereas this exclusion was not applied to the New Haven hospital patients; and (2) on the Midtown patients of office therapists we could secure information about neither their age nor their religious

affiliation. Accordingly, in Table 16-2 we can present only prevalence rates (per 100,000 estimated corresponding population in each Midtown religious group) of age 20 to 59 patients in mental hospitals and psychiatric clinics.[9]

Table 16-2. *Midtown Treatment Census* (Age Inclusive), Prevalence Rates (per 100,000 Population) of Midtown Patients (Age 20–59 Only) in Hospitals and Clinics by Religious Groups

Treatment sites	Catholic	Protestant	Jewish
Hospitals:			
Public	659	385	250
Private	33	61	148
Total in-patients	692	446	398
Total clinic out-patients	108	103	380

Within the indicated limitations of the Midtown patient data, we see in Table 16-2 that the public hospital rate is lowest in the Jewish group, half-again higher among Protestants, and higher by over 2.5 times among Catholics. With private hospital frequencies, however, the group ranking is exactly reversed. As a result, when the two sets of in-patients are taken together, the total hospitalization rates of Protestants and Jews for all practical purposes are alike, both still being appreciably below the Catholic frequency. Thus, the Jewish-Protestant difference in public hospital rates is practically wiped out when total in-patients become the measure.

Moving next to the psychiatric clinics, we observe Protestants and Catholics with identical patient rates and Jews with a frequency almost four times greater.

Among Midtown residents known on one day to all treatment facilities, the reported patients of office therapists aggregated almost half of the total reported. These patients cannot be brought into Table 16-2, but it is obvious that were they included their trend could dominate the Total Patients rates. To discern the direction of this trend, we can apply one of two alternative assumptions. First, on the common element of ambulatory treatment, we might anticipate that interreligion differences in *office therapy* rates would tend to parallel the observed differences in *clinic* frequencies. If so, the Total Patients rate probably would be highest among Jews, with the Catholic rate perhaps exceeding the Protestant frequency by a relatively small margin. Or, on the common element of high treatment costs, we might anticipate that interreligion differences in office therapy frequencies would tend to parallel the observed *private hospital* rates. In this event, the Jews would again emerge with the largest Total Patients rate; but now second position in magnitude of these rates would probably be held not by Catholics but by Protestants. There are intima-

tions in the Midtown Home Survey supporting the second assumption and suggesting that Total Patients rates among Jews, Protestants, and Catholics may stand to each other in a ratio of roughly 7:6:5, respectively. From Treatment Census evidence, this result would reflect the fact that in-patient and out-patient rates tend to vary in opposite directions among the three religious groups.

Comparisons of New Haven and Midtown Treatment Census data should of course be undertaken with caution. With this caveat in mind, attention might be called to the fact that New Haven's interreligious differences in neurosis and character disorder rates (Table 16-1)—principally treated in out-patient facilities—parallel Midtown's differences in observed clinic patient frequencies (Table 16-2). That is, in both communities Jews seem to emerge with higher ambulatory treatment rates and Total Patients frequencies than either Protestants or Catholics.

What is the meaning of the seemingly convergent findings from the two studies? An anthropologist's review of the literature on this general question, published a few years before the New Haven study, concluded:[10]

> The factual residue thus appears at present to be: American Jews have a lower incidence of [hospitalized] insanity than non-Jews. . . . When it comes to the matter of neurosis, psychiatric opinion holds that Jews are more neurotic or anxiety ridden than non-Jews . . . A. B. Brill, Abraham Myerson and Israel S. Wechsler may be mentioned as exponents of this view.
>
> The causes of Jewish neurosis are attributed by these authorities to the taboos and inhibitions of Mosaic law, to the unconscious "incest motive" resulting from exceptionally close ties within the Jewish family, to exclusion from manual activity and "seclusion into a world of life predominantly cerebral," and to the tensions of minority life.
>
> Generalizations by practicing psychiatrists, however, invite errors resulting from the selective nature of their experience. . . . The only empirical verification comes, as usual, from studies of college students, and these studies (conducted by psychologists) are by no means in unanimous agreement on the hypothesis of neurotic Jewish personality.

HOME SURVEY SAMPLE: MENTAL HEALTH DISTRIBUTIONS BY RELIGIOUS ORIGIN

To move to new ground on the inclusive question of interfaith differences in mental health, we can proceed now to the evidence provided in the sample of 1,660 Midtown adults studied by our Home Interview Survey. Here we of course apply as yardstick the Midtown psychiatrists' classification of the mental health status of each sample respondent. Although this classification scheme lacks the nosological specificity of clinical diagnosis, the Home Survey in another direction avoids a difficulty inherent in the use of institutional records, at least when religious

groups are the focus of attention. This difficulty is that at institutional intake, information about religion of the patient as a rule is rather less than carefully ascertained and recorded. By contrast, in the Midtown interviews as many as 15 separate questions were asked about the individual's religious orientation, identification, and behaviors, past and present.

Discussed in Chapter 2 of this volume was the distinction between independent and reciprocal demographic variables. Obviously, the individual's religious identification can change between childhood and adulthood, and such change may be consequences of personality processes that also work themselves out in forms subsumed under the concept of mental health. Thus, adults' replies to the interview question, "To what religious faith do you *now* belong?" must be considered in the nature of a concurrent, reciprocal, and etiologically ambiguous variable relative to their mental health. On the other hand, in replies to questions on the faith that each parent grew up in, we have the individual's religious origin, potentially standing as an antecedent and independent variable to the dependent variable of his current mental health.

We shall presently consider changes in religious identification between parents and their adult offspring. But here we first want to classify the sample adults by religious origin and to examine the mental health distribution in each of the four religious categories shown in Table 16-3.

Table 16-3. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Religious Origin

Mental health categories	Religious origin			
	Catholic	Protestant	Jewish	Others*
Well	16.1%	22.6%	16.0%	22.6%
Mild symptom formation	35.4	36.1	41.7	30.1
Moderate symptom formation	22.2	19.8	25.8	20.8
Impaired	26.3	21.5	16.5	26.5
Marked symptom formation	13.9	12.5	11.3	17.0
Severe symptom formation	9.0	6.9	3.8	5.7
Incapacitated	3.4	2.1	1.4	3.8
N = 100%	(832)	(562)	(213)	(53)

* Almost two-thirds of these respondents had parents who were identified as Christians of the Eastern (Greek or Russian) Orthodox Church. The remaining parents were either members of non-Western religious cults or were reported as having grown up in no known religious faith. These respondents are too diverse in religious backgrounds and too few in number to be brought into subsequent analyses in this chapter.

We know that among the religious groups in the sample there are differences in age composition and socioeconomic origin. We have previously found that these two demographic factors are independently

related to respondent mental health. Thus, if interesting differences appear in Table 16-3, there is a decided chance that these differences are not real, but rather are spurious results of intergroup variations in age and SES origin. In Table 16-4, we present the mental health distributions that could be expected were the three religious-origin groups identical in these latter respects.[11]

Table 16-4. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Mental Health Classification by Religious Origin as Standardized for Age and SES Origin

Mental health categories	Religious origin		
	Catholic	Protestant	Jewish
Well	17.4%	20.2%	14.5%
Mild symptom formation	34.5	36.4	43.2
Moderate symptom formation	23.4	19.9	25.1
Impaired	24.7*	23.5	17.2*
N = 100%	(832)	(562)	(213)

* $t = 2.6$ (.01 level of confidence).

This standardization almost completely levels the Protestant-Catholic differences seen in Table 16-3. The impairment differences observed between Jews and the other two groups in the table remain statistically significant, however. Reference to Table 16-3 locates the Jewish difference specifically in smaller Severe and Incapacitated frequencies, i.e., at the end of the impairment range rather than in the Marked category.

On the other hand, in Table 16-4, Jews are also seen with the lowest prevalence of Wells at a not insignificant distance from the Protestants' Well frequency. With the lowest rates both of the Well and the Impaired, Jews of course are found more heavily concentrated than Protestants or Catholics in the subclinical range in between, above all in the most populated mental health category, namely, Mild symptom formation.

We might follow the matter one step further. Supose we look at the religious-origin groups within each of the three SES-origin strata, retaining standardization for age differences. We then find in all three strata the essential mental health picture discerned in Table 16-4. However, there are differences of degree—the most suggestive appearing in the lower stratum (E–F) of SES origin. Here respondents of Protestant, Catholic, and Jewish origin have almost identical Well frequencies, but their Impaired rates are 32.0, 30.5, and 19.4%, respectively.

If Jews convey the most favorable group picture of mental health in the SES stratum having the highest concentration of mental morbidity, then one possible hypothesis that can be suggested for future testing is

this: Midtown respondents of Jewish parentage tend to reflect some kind of impairment-limiting mechanism that operates to counteract, or in some degree contain, the more extreme pathogenic life stresses during childhood. This hypothesis appears to be consistent with the repeatedly confirmed relative immunity of Jews to such self-impairing types of reactions as alcoholism[12] and suicide.

If such a "this-far-and-no-farther" control mechanism exists, its source is a question that here can only be a subject of speculation. One factor often hypothesized by psychiatrists as potentially pathogenic is the strong Jewish family structure. However, this factor may conceivably be eugenic on balance, in the specific sense that powerful homeostatic supports are brought into play at danger points of crisis and stress that in other groups may be unbalancing for the family and impairing for the individual.

If subsequent investigation should lend support to this inference, the mechanism involved may have historical, broadly psychosocial roots, of a kind defined by the following hypothesis: A group that for thousands of years has been beleaguered by chronic environmental threats of destruction survives by developing internal processes of resistance, deep within the dynamics of the family itself, that counteract in some measure the more extreme kinds of exogenous crises and check the more extreme forms of pathological reaction.

Also potentially relevant, although stemming from another framework, is the inference Janis[13] draws from his classic study of surgery patients:

> Arousal of some degree of anticipatory fear may be one of the necessary conditions for developing inner defenses of the type that can function effectively when the external danger materializes. . . . If a person is given appropriate preparatory communications before being exposed to potentially traumatizing stimuli, his chances of behaving in a disorganized way . . . may be greatly decreased. Thus, from the standpoint of preventive psychiatry, it is of considerable importance to determine how preparatory communications can be made to serve an effective prophylactic function.

To translate this formulation for the present discussion, mobilization of anxiety about the instability of the Jewish exilic environment may historically have been established as a conditioning pattern of the Jewish family structure. In one direction, such anxiety, subsequently magnified in the adult by extrafamily life conditions, may be reflected in our finding of an unusually large concentration of Midtown Jews in the subclinical Mild category of symptom formation. On the other hand, this large component of historically realistic anxiety, as generated in the Jewish family, may function prophylactically to immunize its children against the potentially disabling sequelae of the more severe pressures and traumas of existence.[14] Later in this chapter we may see other expressions of this process.

Also to be emphasized is that, like earlier studies of patients, the Midtown Home Survey shows a somewhat higher over-all frequency of mental morbidity in the Catholic group than in the Protestant group. However, this difference was found to be a wholly spurious consequence of the fact that Protestants in the aggregate are younger and of considerably higher socioeconomic antecedents than are Catholics.

HOME SURVEY SAMPLE: MENTAL HEALTH AND PARENTAL RELIGIOSITY

In the section preceding we have been concerned with the respondent's religious origin as based on the faith in which his parents had grown up. This is a formal, demographic kind of classification, but it tells us nothing about the degree of parental commitment to the doctrines, commandments, and practices enjoined by their religious institution.

Seen in historical perspective, this dimension of individual commitment to the tenets of the faith—or "religiosity"—is extremely sensitive to changes in the environing society. The Protestant Reformation is an excellent case in point. The period in which our respondents' parents had been born roughly spanned the half century from 1864 to 1914. These, of course, were years that saw vast scientific, technological, and economic changes which made themselves felt along the entire broad front of Western institutions. Not the least of these impacts registered on the church and on the individual's anchoring ties to it.

We can hypothesize that this factor of relative religious anchorage or commitment had direct effects on parents' roles and on the home atmosphere, with radiating consequences for the development of the child as observed when he himself had grown into adulthood.

Interviewing each respondent, we asked this key question as a shortcut approach to his parents' religious orientation:[15] "How important would you say religion (belief in religion) was to your parents? For example, would you say it was: Very important? Somewhat important? Or not important at all?" [16]

We were of course aware that a reply to this question is essentially the respondent's judgment applied to his recall of observed words and deeds as they reflected parental attitude toward religious tradition.[17] We could assume that the judgment hinged in part on a norm or image of the "faithful" man that is specific to each church system and, in part, on the respondent's recall of reality modifications in this ideal among the parents' local contemporaries.

Within the Study's taxonomy of test factors,[18] parental religiosity certainly stands to the dependent variable of respondent mental health as a chronologically antecedent factor. But we deal with the respondent's *judgment* of such religiosity, and this "filter" is potentially open to in-

fluence from psychological processes related to the dependent variable. However, parental religiosity qualifies as an independent, as well as antecedent, test factor to the extent that the respondent's judgment took its measure from long and relatively close observations of parental behavior. We can produce no evidence to illuminate this issue. As a matter of the investigators' opinion, however, until shown otherwise we will assume that respondents' reports of parental religiosity provide a reasonable approximation of independence from the dependent variable.

A final preparatory point must now be clarified. Earlier in this chapter, the respondent's religious origin was used, as determined by the criterion of descent through the religion of parents' upbringing (much as had nationality origin in the preceding chapter). This criterion was appropriate to our purposes of inclusive demographic classification at that point. With religiosity now the factor of central interest, we must gear this factor to identification of religious groupings based on a more refined criterion. That is, instead of religious origin or descent of parents, we refer to this criterion as parents' *religious-group identification,* as ascertained from respondent replies to the interview question: "What religious faith did *you* grow up in?"

Of course, the religion a parent had experienced during his own childhood tells us nothing with certainty about his religious identification during adulthood. However, we can be confident that the religious tradition which enveloped the child is a fairly reliable indicator of the religious-group identification conveyed, however minimally, by his parents. This criterion, of a specific religious identification *conveyed* to one's children, is the basis for our present classification of respondents' parents by religious group.

With a locus in any given religious system, individuals vary in degree of acceptance of its disciplining claims upon their thought and behavior. In this perspective, parents who had stood with the "faithful," by the light of locally modified standards of the church at large, would likely be seen by the child as having given their religion very important weight in their lives. On the other hand, parents deviating considerably from the faithful model, while remaining more or less anchored in the church, would probably be judged as holding their religion no more than "somewhat important." Finally, parents remaining formally identified as in the fold of the church but whose behavior suggested that its religious tenets were to them "not important at all" were probably at best peripheral, nominal members of the institution.

Let us first record how the sample respondents' parents are distributed on this gross scale of reported religiosity:[19]

Very important (rVI).....52%
Somewhat impotant (SI).....37%
Not important at all (NIAA)...11%

Table 16-5 shows next how respondents' parents located within *each group fold* are distributed by religiosity as reported to us. We need not

Table 16-5. *Home Survey Sample* (Age 20–59), Distributions of Respondents' Parents on Religiosity Classification by Parental Religious-group Identification

Parents' religiosity	Parents' religious-group identification		
	Catholic	Protestant	Jewish
Very important (VI).....	67.4%	40.0%	31.1%
Somewhat important (SI).....	28.1	45.8	48.4
Not important at all (NIAA)....	4.5	14.2	20.5
N = 100%.....	(805)	(541)	(190)

pause to speculate on the explanations for the differences that appear in Table 16-5.[20] However, they are consistent with general observations that close conformity to the normative expectations of one's religious institution characterizes more adherents of the Catholic church than Protestants or Jews.

Furthermore, if we could assume that at some not-too-distant period in the past almost all adherents of each religious faith were in the top level of religiosity, it seems apparent that this was far from the case among the respondents' parents a generation ago. Even within the relatively stable Catholic group, one in every three parents in the eyes of their offspring stood at less than a very important level of religious commitment. Thus, the erosions of traditional religious anchorages among adults of a generation ago can seemingly be discerned from the data presented in Table 16-5.

Our primary concern here is addressed to this question: What are the detectable consequences of parental differences in religiosity for the mental health of the children they raised to adulthood? Let us first direct this question to the Midtown sample respondents of Jewish-identified parents. In Table 16-6 they are distributed on a threefold classification of the mental health continuum.

Among offspring of the several religiosity categories of Jewish parents, no significant difference in mental health composition is to be seen. In the light of the relatively small number of cases in the two extreme columns of Table 16-6, we must consider our evidence from the Jewish segment of the Midtown sample as statistically inconclusive.

The difficulty of insufficient sample numbers is not encountered to the same degree among respondents of Protestant-identified parentage. In fact, this group is sufficiently numerous to be examined on our present test variable as subdivided by our three-way stratification of parental

Table 16-6. *Home Survey Sample* (Age 20–59), Distributions of Respondents with Jewish-identified Parents on Mental Health Classification by Parental Religiosity

Mental health categories	Parental religiosity		
	VI	SI	NIAA
Well	8.5%	18.5%	15.4%
Mild-Moderate	76.2	63.0	64.1
Impaired	15.3	18.5	20.5
N = 100%	(59)	(92)	(39)

socioeconomic status. In Table 16-7 we present the mental health distributions only for the respondents who are of upper-SES descent (A–B).

Table 16-7. *Home Survey Sample* (Age 20–59), Distributions of Respondents from Upper SES-origin and Protestant-identified Parents on Mental Health Classification by Parental Religiosity

Mental health categories	Parental religiosity		
	VI	SI	NIAA
Well	26.7%	25.7%	27.0%
Mild-Moderate	56.5	55.0	56.8
Impaired	16.8	19.3	16.2
N = 100%	(101)	(109)	(37)

Mental health composition is almost identical in the three religiosity categories of Table 16-7. However, when we similarly categorize respondents of Protestant-identified parents who had been in our middle or lower strata of socioeconomic status, we find a rather different pattern of mental health composition. Since the pattern is quite similar in these parental strata, and the number of cases is relatively small in the lower of the two, Table 16-8 combines the respondents of these two SES-origin groups (C–D and E–F).

If the VI- and SI-reared respondents are alike in their Well frequencies, the latter are better off in having a significantly lower Impaired rate, accompanied by a correspondingly higher frequency in the subclinical (Mild-Moderate) range of the continuum. Relative to these two groups, moreover, the NIAA-sired respondents have the largest impairment rate and the smallest Well representation.

In short, we discern the most favorable mental health picture in the SI religiosity column and the least favorable in the NIAA segment, with the VI category standing more or less intermediate. On the yardstick of

Table 16-8. *Home Survey Sample* (Age 20–59), Distributions of Respondents of Lower and Middle SES-origin and Protestant-identified Parents on Mental Health Classification by Parental Religiosity

Mental health categories	Parental religiosity		
	VI	SI	NIAA
Well	20.9%	22.3%	12.5%
Mild-Moderate	51.3	60.4	50.0
Impaired	27.8*	17.3†	37.5*†
N = 100%	(115)	(139)	(40)

* $t = 2.1$ (.05 level of confidence).
† $t = 2.9$ (.01 level of confidence).

impairment rates, therefore, the pattern of relationship between parental religiosity and respondent mental health can be described as being of the general J-curve type.

Of course, the generality of this pattern remains in question when we consider that it does not seem to appear among Jewish-bred respondents or among Protestant-reared people of high SES origin. However, respondents of Catholic-identified parents have not yet been examined in this respect. Analysis reveals the presence of this distribution pattern among such Catholics on *all* three SES-origin strata. However, because the number of respondents with NIAA parents is so small in each of these strata, we can best delineate the pattern by viewing, in Table 16-9,

Table 16-9. *Home Survey Sample* (Age 20–59), Distributions of Respondents with Catholic-identified Parents on Mental Health Classification by Parental Religiosity

Mental health categories	Parental religiosity		
	VI	SI	NIAA
Well	17.1%	15.0%	5.5%
Mild-Moderate	56.0	63.3	58.4
Impaired	26.9	21.7	36.1
N = 100%	(543)	(226)	(36)

the entire Catholic-identified group as differentiated in terms of parental religiosity.

Although the intra-Catholic differences in Table 16-9 do not achieve firm statistical significance, we again see the lowest Well frequency and highest Impaired rate in the NIAA column. Moreover, the SI category again emerges with the smallest prevalence of impairment; the VI respondents in turn stand intermediate in this respect.

All in all, therefore, the J-curve pattern observed among Protestant-sired respondents of lower and middle SES origins seems to be paralleled among Catholic offspring of all SES-origin strata. We can thereby infer, first, that this is a key pattern for respondents from both Protestant and Catholic childhood homes that were of lower or middle socioeconomic position. Jews of such SES origin do not seem to fit this pattern, but because of their small numbers in these strata, we lack confidence that this negative finding in their case is statistically conclusive.

Second, we can infer that a finding of no relationship between parental religiosity and respondent mental health seems to characterize both Protestants and Jews of upper socioeconomic descent. Here, Catholics of like SES origin seem to deviate, presenting instead the J shaped curve. However, their number in this stratum is relatively small, and we cannot be sure that this positive finding in their instance is statistically stable.

Accordingly, we are left with the residual inference that in lower- and middle-class homes, parental religiosity tends to be related to childrens' adult mental health—at least if the home had been Protestant or Catholic identified.

To be sure, the affinity uncovered in these parental-SES strata is not strikingly strong. On the other hand, this relationship has come through a measure of religiosity that rests on the narrow base of a single interview question and offers only a crude trichotomous classification. Accordingly, it is a plausible expectation that with a broader base of information and more refined classification of parental religiosity the relationship may well emerge in clearer form and enlarged magnitude.

Suggestive evidence lending support to the link between parental religious behavior and offsprings' mental health comes from a study of King and Funkenstein, who report:[21]

> . . . there is a constellation of psychological and sociological factors which are associated with the cardiovascular reactions of healthy subjects [male college students] in acute stress. The constellation includes the immediate emotional reaction of the subject, his attitudes in the area of religious values, his perception of parental behavior in discipline, and the *church-going behavior of his parents* [italics added]. . . . We leave it to further research to spell out the manifold implications of these associations. We do suggest that they are of sufficient strength to encourage further inter-disciplinary research among the fields of physiology, psychology and sociology.

From another context, a leading mental hospital chaplain has observed: "We have found that, with the mentally ill, religion and its faith and practices have sometimes been used as a means of control, domination or manipulation with marked and serious emotional consequences." [22]

The relationship seemingly discerned in the Midtown sample poses a series of questions that cannot be answered at this time. First, why is

this relationship apparently specific to the lower two-thirds of the parental-SES range and seemingly nonoperative among respondents from the upper third of that SES range? What specific elements can explain why the VI type of home in the susceptible SES strata seems to be more eugenic for offsprings' mental health than the NIAA home, and why does the SI home tend to be the most eugenic type of all? Under the secularizing pressures of industrial, urban society, are different modes of religiosity chosen by parents of broadly different types of personalities? If so, the apparent consequences of parental religiosity for offsprings' mental health may partially dissolve themselves into consequences of more comprehensive aspects of parents' characters.

On the other hand, assume broad personality similarities in a group of parents who diverge in religiosity: What consequences of the latter variable alone would flow into the intrafamily processes, e.g., into performances of parental roles, and thereby into the psychological conditioning of their offspring? What effects do variations in parental religiosity have upon family stability under crisis? For children, especially in adolescence, what are the intrafamily consequences when they veer away from the religious orientation of parents under pressure of peers and larger social influences?

By the inroads made into the religious anchorages of a large segment of the population, we see one cutting edge of the vast sociocultural changes of the past century. In particular we have seen the impacts of these historical forces on the religious moorings in the generation parental to our sample adults, and we can glimpse possible residues of such forces in the mental health of these respondents.

MENTAL HEALTH AND RELIGIOUS MOBILITY

We have been concerned about presumptive changes in religiosity among parents who had been identified with a specific religious group. Here we focus on direct evidence of a more drastic kind of change—among respondents in this instance, namely, a change in religious-group *identification* itself, or what we shall call *religious mobility.*

For respondents' religious-group lineage we shall take their religious origin, and we shall compare this with their replies to the interview question: "To what religious faith do you *now* belong?" In Table 16-10 we can ascertain the relative prevalence of religious mobility in the Midtown sample population.

This table clearly shows that respondents of Protestant or Jewish origin have total religious mobility rates (21.4 and 24.4%) more than twice that of Catholic-derived people (10%). However, in all three origin groups most of the movement has been not into another group, but into the disidentified no faith or "unchurched" ranks.

Table 16-10. *Home Survey Sample* (Age 20–59), Distribution of Respondents' Current Religious Group by Their Religious Origin

Current religious group	Religious origin		
	Catholic	Protestant	Jewish
Catholic	90.0%	4.1%	1.9%
Protestant	2.5	78.6	1.9
Jewish	0.0	0.4	75.6
None	5.8	14.2	16.9
Other	1.7	2.7	3.7
N = 100%	(832)	(562)	(213)

Of particular relevance to us here is the mental health composition of the several subgroup segments that have sufficient numbers of cases. Given the number of these segments, perhaps the most summary indication of such composition might be in terms of the Impaired-Well ratio,[23] as presented in Table 16-11.

Table 16-11. *Home Survey Sample* (Age 20–59), Impaired-Well Ratio of Sample Respondents by Religious Origin and Current Religious Group

Current religious group	Religious origin		
	Catholic	Protestant	Jewish
Catholic	163	57	...
N* =	(747)	(23)	(4)
Protestant	25	87	...
N =	(21)	(442)	(4)
Jewish	...	...	92
N =	(0)	(2)	(161)
None	200	170	120
N =	(48)	(80)	(36)

* N is the total number of respondents in the specific cell to which the Impaired-Well ratio value refers.

As we have just seen, Protestants who changed to Catholicism and Catholics who shifted to Protestantism are small in numbers. But to judge from the Impaired-Well ratios as derived from so few cases, such church-to-church changers appear in a somewhat more favorable mental health condition than do the stable Protestants and Catholics. Compared to the latter and the nonmobile Jews, however, the currently unchurched *respondents* from all three religious-origin groups uniformly present a less favorable mental health picture.

Since religious mobility is in the realm of voluntary behavior, it seems likely in large part to be psychologically determined. Hence, Table 16-11 probably tells us more about the kinds of people who change their religious group identification than it reveals about the mental health consequences of such change.

A potential programmatic utility of the data is to highlight to metropolitan religious organizations the mental health weighting of adherents they are losing to the unchurched, unreachable condition.

HELP-NEED, THE PATIENT-HISTORY VARIABLE, AND PROFESSIONAL ORIENTATION

We turn finally to the patient-history factor as applied exclusively to the population at help-need, namely, the sample respondents who are in the Impaired category of mental health. Because religious origin is the most comprehensive criterion for classification by religious grouping, it is used with the Impaired segment of the sample in Table 16-12.

Table 16-12. *Home Survey Sample* (Age 20–59), Distributions of Impaired Respondents on Patient-history Classification by Religious Origin

Patient history	Religious origin		
	Catholic	Protestant	Jewish
Current out-patients	1.8%	8.3%	20.0%
Ex-patients	19.7	24.0	20.0
Never-patients	78.5	67.7	60.0
N = 100%	(219)	(121)	(35)

Of course, the ex-patients shown in the table include people who had been hospitalized, as well as those who had used ambulatory facilities. Accordingly, if the ex-patient rates are quite similar in the three columns of the table, we can be sure—from our Treatment Census data earlier reviewed—that the exhospitalized representation in the "mix" is quite different in the three religious groups.

More clear-cut are the current out-patient frequencies. We discern that among those now in a state of help-need, Jews have a current out-patient rate more than twice that of Protestants and approximately ten times that of Catholics. This illuminates the finding earlier drawn from the New Haven Study and our Treatment Census analysis that Jews emerge with higher ambulatory treatment rates than either Protestants or Catholics.[24]

From our Home Survey sample we have already seen (Table 16-3) that Jews have a lower impairment rate than either of the other two re-

ligious groups. This seemed to be at direct variance with the Treatment Census finding that Jews were the highest of the three groups in Total Patients rates. The seeming paradox is set aright by the finding that between two groups of like size a low mental morbidity rate and a strong tendency to seek therapy can bring more Impaired people to a treatment facility than a high morbidity rate and a relatively weak tendency to seek therapy.

This statement stands irrespective of the fact that determinants other than mental morbidity enter into the varying motivations that lead one to treatment—especially of the voluntary out-patient type. One of these determinants is certainly the Impaired respondent's socioeconomic status. When the latter factor among the Impaired is controlled, the interreligious differences in current out-patient rates are narrowed but by no means eliminated. In most previous studies of patient populations sorted by religious groupings, lack of control for the SES variable has obscured its contribution to the large interreligious differences in patient rates.

However, that more than socioeconomic status is involved in patient rate differences may be gathered from questions put to the Midtown sample adults bearing on a dimension that we designate *professional orientation.* This was derived from our Midtown respondents through open-ended questions that posed certain psychiatric problems in a hypothetical family. One question was: "Let's suppose some friends of yours have a serious problem with their child. I mean a problem with the child's behavior, or difficulty getting along with others. The parents ask your advice what to do. What would you probably tell them to do about it?" A similar query was phrased in terms of an advice-seeking friend with a problem spouse.

Respondents were first sorted into those who in either or both situations would recommend consulting a psychotherapist of some kind. Sorted next were all the remaining respondents who would advise seeing a physician. In the third category were placed those who at most would refer such friends to some other kind of professional person, principally a clergyman or member of a social agency staff. The residue contained all respondents whose replies to both questions contain no suggestion of professional help of any kind.

Since professional orientation is strongly related to socioeconomic status of respondents, in Table 16-13 distributions on the former variable appear standardized for respondents' own SES. The criterion of classification by religion is again religious origin.

Catholics and Protestants are alike in that within each group about half could perceive no professional help as relevant for either of the stipulated problem families, and about one in eight would refer such problems to a physician. They differ in that fewer Catholics than

Table 16-13. *Home Survey Sample* (Age 20–59), Respondents' Distributions on Professional Orientation Scale by Religious Origin as Standardized for Own-SES Differences

Respondent recommendation	Religious origin		
	Catholic	Protestant	Jewish
Psychotherapist	23.8%	31.4%	49.2%
Physician	13.3	12.5	7.9
Other professional	13.0	7.5	3.1
Nonprofessional	49.9	48.6	39.8
N = 100%	(832)	(562)	(213)

Protestants would recommend a psychotherapist, and correspondingly more Catholics would advise other kinds of professionals, principally clergymen.

Jewish respondents, to a degree well beyond the other groups, see psychotherapists as the most appropriate source of help for the disturbed individuals outlined to them. In fact, they are the only group where this response is more frequent than the "no professional" recommendation.

Table 16-13 views the Midtown sample in its entirety, whereas Table 16-12 views only the Impaired portion of that sample. Nevertheless, as observed in Table 16-13, the religious groups' rank order of orientation to psychotherapy corresponds to their rank order of current out-patient rates seen in Table 16-12. Independently of socioeconomic status, then, religious groups differ in their spontaneous awareness of and receptivity to the psychotherapeutic professions. Given a help-need condition and like socioeconomic status, these differences are manifested through intergroup variations in actually seeking the counsel of a psychotherapist. This generalization is consistent with the evidence provided earlier in the present chapter by both the Treatment Census and Home Survey operations of the Midtown Study.

It is now relevant to note the discussion on this point by the New Haven investigators of a patient population:[25]

> It is our opinion that the acceptance of psychiatry probably accounts for the inordinately high rate of psychoneurosis among Jews.[26] The explanation for this must be considered in terms of the ethnic structure and the tradition of the Jewish group in addition to its religious organization. Among Jews it is generally accepted that there is no conflict between religious doctrine and psychoanalytic theory. This is in contrast to a partially supported opposition among Catholics. From the standpoint of community attitudes, the Jews exhibit a high level of acceptance of psychoanalytic psychiatry with a minimum of disturbance of their social values. The Jewish attitude is widely divergent

from the Irish, as is substantiated by our finding that not a single patient of Irish birth was receiving psychotherapy for psychoneurosis. Although this explanation of the rates of psychoneurosis in terms of the acceptance of modern psychiatry appears plausible, we cannot definitely state that the actual occurrence of the illness is not higher among Jews.

The statement just quoted, on one point at least, finds support in the implication of Midtown data just reviewed that readiness for psychotherapy, or the "pro-psychiatry" attitude, among Jews contributes to their high patient rates. However, the explanation offered by the New Haven investigators for the Jewish acceptance of psychiatry, seems to rest primarily on a contrast drawn from the Catholic group. We understand the New Haven authors to posit that official opposition of the church, at least to psychoanalysis, diverts Catholics from seeking psychotherapy of *any* kind. In the Jewish group, further, the lack of such hieratic and doctrinal opposition and a "minimum of disturbance with their social values" are essentially negative factors in the sense that they do *not* interpose barriers to soliciting psychiatric help.

In our view, this formulation is unduly simplified. First, Protestantism, at least in its metropolitan churches, if anything is more overtly active in articulating itself to psychiatry than are synagogues on the whole. On this basis, according to the New Haven reasoning, the pro-psychiatry frequencies of Protestants should be substantially larger than those of Catholics and at least approximate those of Jews. Table 16-14 reveals these frequencies by religious group as sorted into respondent own-SES strata.

Table 16-14. *Home Survey Sample* (Age 20–59), Pro-psychiatry Frequencies among Religious-origin Groups by Respondent Own SES *

Own SES	Religious origin		
	Catholic	Protestant	Jewish
Lower (E–F).....	12.1%	13.8%	†
N = 100%.....	(381)	(137)	(11)
Middle (C–D).....	23.6%	28.6%	41.3%
N = 100%.....	(322)	(168)	(46)
Upper (A–B).....	35.6%	51.8%	63.4%
N = 100%.....	(129)	(257)	(156)

* Needless to say, a group's distribution on the own-SES range may deviate considerably from its scatter on the parental-SES range.

† These cases are too few to present a meaningful percentage.

In two of the three SES strata, the pro-psychiatry rates of Protestants and Catholics do not differ appreciably. In the upper stratum the

Protestant frequency stands no better than roughly intermediate between those of Catholics and Jews. Accordingly, our data suggest that if there are differences in psychiatric orientation among the clergy of the three major religious groups, they appear to have no power to explain the variations in psychiatric readiness observed above among their respective laities.

The information in Tables 16-13 and 16-14 enable us to question the New Haven formulation offered to explain the "high level of acceptance of psychoanalytic psychiatry among Jews." This hypothesis emphasized the absence among Jews of clerical and doctrinal constraints to securing psychotherapy. The alternative hypothesis we would propose emphasizes not the absence of constraint but rather the presence of a positive motivating process, and looks for it not in the religious institution alone but in the spontaneous operations of the family unit as well.

Earlier in this chapter (Table 16-4), we reported that in mental health composition Protestants and Catholics are little different when standardized by age and SES origin, whereas by comparison Jews have a significantly lower impairment frequency and a higher subclinical (Mild or Moderate symptom formation) rate. Furthermore, we observed that the Jewish deviation in impairment frequency was sharpest in the SES-origin stratum that is associated with the most pathogenic life conditions, namely, the lower class. We therefore indicated that the Jewish mental health distribution suggests the possible presence in the family unit of an impairment-limiting mechanism that operates to counteract or contain in some degree the more pathogenic life stresses. Consistently low rates of self-impairing alcoholism and suicide in the general Jewish population seemed compatible with this hypothesis.

We have since seen in the Midtown sample that, given an Impaired state of mental health, Jews have far higher current patient rates than Protestants or Catholics. Furthermore, Jews generally tend to deviate from the other two religious groups of like socioeconomic status in their pro-psychiatry orientation. We would now extend the postulate of an impairment-limiting mechanism to cover its manifestations in greater Jewish responsiveness to psychotherapy as an appropriate means to limit and reverse psychopathology.

It would go somewhat outside our present framework to develop the further suggestion that this mechanism may be part of a larger survival-ensurance process rooted in the Jewish family and religious tradition that has found expression in these other varying forms: (1) explicit emphasis upon health as transcending fundamental religious prescriptions when the two are in conflict; (2) mobilization of family and kin in psychological and material support of the sick individual; and (3) pragmatism in calling upon extrafamilial healing resources.[27] The fusion of all these elements may perhaps be discerned in the millennial-long affinity of

Jews for the field of medicine and, more recently, for its psychiatric branch, in the several roles of explorers, healers, and patients. The Jewish group historically can be viewed in one perspective as a culture mobilized for the prevention and, that failing, for the healing of the ailments of body and mind.

Finally, we would question the inference of the New Haven investigators that opposition to psychoanalysis (as a mode of therapy) on the part of the Catholic laity is "partially supported" by the church.

There is no question about the church's unequivocal reactions to the antidoctrinal aspects of the psychoanalytic literature. Overlooked, however, is the impressive movement of church spokesmen toward explicit acceptance of Freud's scientific and therapeutic contributions.

As one churchman has put it: "A Catholic will differ radically with Freud in philosophy and religion. But such differences, radical and profound though they be, should not obscure our vision nor dim our appreciation of the many fresh and brilliant insights which he brought to the understanding of the forces moving in the subconscious areas of our mental life and exercising their pull upon us." [28] Commenting on the address of Pope Pius XII to the First International Congress on the Histopathology of the Nervous System, the Vatican's official newspaper observed: "All the systems of psychoanalysis have in common certain principles, methods and psychic experiments which are in no way contrary to rational ethics and Christian morality, and therefore are not in any way touched or reproved by the Sovereign Pontiff." [29]

Several months later Pope Pius told the Fifth International Congress on Psychotherapy and Clinical Psychology, "Be assured that the church follows your research and your medical practice with Her warm interest and Her best wishes. You labor on a terrain that is very difficult. But your activity is so capable of achieving precious results for medicine, for the knowledge of the soul in general, for the religious dispositions of man and for their development. May Providence and divine grace enlighten your path. In pledge thereof We impart to you with paternal benevolence Our Apostolic Benediction." [30]

From another approach we postulate that two major institutional influences, among others, may operate to restrain financially capable Catholics from seeking ambulatory psychiatric care more often. Psychotherapy tends to be seen as a secularized form of a central church procedure: the confessional. In this perspective the therapist need not be a cleric, but considerations of personal comfort in the therapeutic relationship may dictate that he should be a fellow Catholic. On this line of reasoning, the Midtown Catholics' relatively low patient rates and infrequent psychiatric readiness may partially be a function of the plain fact that Catholic clinics and office psychiatrists are so few in number.

SUMMARY

Religious differences comprise the final demographic variable explored in the Midtown data for lines of connection leading to the several facets of mental health under review in this volume. The principal exploratory results are as follows:

1. Despite technical differences between the Midtown Treatment Census and New Haven Psychiatric Census, intercommunity comparison revealed these parallels: (*a*) For the kinds of disorders usually treated in an ambulatory facility, Catholics and Protestants yielded like patient rates that were considerably below that found among Jews; (*b*) for the kinds of disorders usually treated in hospitals, Jews and Protestants yielded like patient rates that were below that of Catholics; and (*c*) taking Total Patients rates as an inclusive yardstick, Jews stood highest in both communities.

2. Clarification of these seemingly contrary directions was sought in the Midtown Home Survey sample of 1,660 representative adults. On the chronologically antecedent criterion of parental religion, the sample's groups of Jewish, Protestant, and Catholic derivation had impairment rates of 16.5, 21.5, and 26.3%, respectively.

Standardization for intergroup differences in age and SES origin reduced the Protestant and Catholic groups to near identity in mental health distributions. Respondents of Jewish origin retained a significantly lower Impaired rate—one wholly explained by smaller numbers in the Severe and Incapacitated subcategories of impairment. However, they were relatively underrepresented in the Well category and overrepresented in the Mild-Moderate range of symptom formation.

Analysis further revealed that the more favorable impairment rate of the Jewish-origin group was principally characteristic of its low SES-origin members. A number of hypotheses and speculations were advanced as possible explanations of these findings.

3. Within each religious-origin group we differentiated respondent parents on a threefold gradient of religiosity, i.e., commitment to and anchorage in their faith. For the first time in this volume, parental religiosity was admitted to analysis not as a demographic variable but as a component factor substantively relevant here—and one illustrative of the order of variables to be systematically treated in the monograph's second volume.

Reflected in the data were substantial erosions in religious moorings among adults of a generation ago. The Midtown evidence further suggested a J-curve type of relationship between parental religiosity and offspring mental health in Protestant and Catholic families adhering to the lower two-thirds of the SES-origin range. Seemingly discernible here

were the echoes in contemporary adults of the reverberating sociocultural upheavals generated during the nineteenth century.

4. Modeled after SES mobility (Chapter 12) was the factor of intergeneration change in religious affiliation. The few converts to other religions were favorably constituted in group mental health, but those who had drifted into the "no religion" stream presented a relatively unfavorable picture of mental health.

5. Focus upon the patient-history variable among the religious groupings' Impaired respondents suggested this: In groups of similar size a combination of low mental morbidity rate and pronounced tendency to seek therapy can deliver more Impaired people to treatment services than a combination of high morbidity rate and slight tendency to seek therapy.

6. Representing the former combination, Jews were also found with a more widespread openness to psychiatry. Reviewed were explanatory formulations of the readiness variable as offered by the New Haven and Midtown investigators.

FOOTNOTES

[1] *Fortune*, vol. 61, no. 2, pp. 2–4, February, 1960.

[2] To avoid unwieldy segmentation, we will not focus on the denominational branches within Protestantism and Judaism. Here, however, we might venture a brief look into our Midtown sample of adults for indications as to the specific denominations represented and their relative size. On the criterion of respondent's report of his own current religious identification, we find the major Protestant denominations in descending order of size to be Episcopalians, Lutherans, and Presbyterians, followed by Methodists and Baptists and a variety of smaller sects.

Similarly the three branches of Judaism are locally represented in a descending sequence by population size, namely, Reform, Conservative, and Orthodox. It may illuminate this denominational distribution to note that only 30% of the Jewish respondents are immigrants, almost 50% are children of immigrants, and roughly 20% are of generation III or beyond.

[3] To avoid monotony of usage, we shall hereafter employ such terms as religion, faith, church, tradition, and persuasion as specific synonyms of "religious group" with which a respondent is personally identified.

[4] Of course, it is necessary to have the total population figure in each group for use as the denominator in calculating its patient rate. The decennial United States census is the source of such information for many kinds of demographic groupings, but religion is not one of these. This deficiency has undoubtedly had crippling effects on epidemiological investigations of the religious factor along the entire range of diseases, somatic as well as psychiatric.

However, application of the Jewish, non-Jewish dichotomy was usually made possible by the availability of local estimates of the Jewish population. These figures were often little more than armchair estimates that by wide and unchallenged repetition had acquired an aura of universal acceptance.

[5] Benjamin Malzberg, "Mental Disease among Jews in New York State, 1920 to 1952," *Yivo Annual of Jewish Social Sciences*, vol. X, 1955, p. 298.

[6] B. H. Roberts and J. K. Myers, "Religion, National Origin, Immigration and Mental Illness," *Am. J. Psychiat.*, vol. 110, no. 10, p. 760, April, 1954.

[7] As in other research of this kind, the New Haven investigators lacked United States census data on religious composition of their community population. Estimates of this composition were apparently extracted from a special survey of a 5% sample

of New Haven residents. Given the sampling error underlying these estimates and the rates derived from them, the above differences in treated psychosis rates seem sufficiently small to be a resultant of chance in the sampling process.

[8] Of course, the New Haven study covered private as well as state psychiatric hospitals. If Protestants and Jews in some numbers preferred such institutions to state hospitals, then patient rates based on the latter alone would of course be an understatement to the extent of such preference.

[9] The absence of the office patients makes it pointless to analyze the remaining patients in each religious group by diagnostic category.

[10] Harold Orlansky, "Jewish Personality Traits: A Review of Studies on an Elusive Problem," *Commentary*, vol. 2, no. 10, pp. 377–383, October, 1946.

[11] This is accomplished by the technique of standardization. In this method, the less-populated mental health categories in the Impaired range cannot be separately sustained. Accordingly, they are merged in Table 16–4.

[12] C. R. Snyder, "Culture and Jewish Sobriety," *Quart. J. Stud. Alcohol*, vol. 16, no. 4, pp. 700–742, December, 1955.

[13] I. Janis, *Psychological Stress*, 1958, p. 352.

[14] Here may also be the seedbed of the Jewish community's proverbial gift, through its long history, for rising from adversity and for converting a handicap into an asset. Alexander King points to another possible consequence: "Jewish humor, as I learned at one of its very sources, was a racial anti-biotic, whose original cultures the children of Israel had carried out of Egypt, more than two thousand years ago, and whose health-preserving properties had been nurtured through the centuries in all the ghettoes and outposts of persecuted Judaism." A. King, *Mine Enemy Grows Older*, 1958, p. 171.

[15] Originally also asked for this purpose was a question on parents' frequency of church (or synagogue) attendance—"when you were growing up." Subsequently, we recognized more fully that as a universal index of religiosity, frequency of church attendance had a number of serious deficiencies. Accordingly, it is not being employed here for this purpose.

[16] If respondent indicated that father and mother differed in this respect, the interviewer recorded the specific nature of the difference. Later, with an eye on the parent likely to have had the larger influence on the home's religious atmosphere, we classified such cases according to importance of religion reported for the mother.

[17] Whether this reply would have coincided with the judgments of the parents themselves, their clergyman, or their friends at the time, is information beyond access to us. Even if accessible, these judgments would not necessarily be of transcending relevance compared to the respondent's judgment from his personal vantage point.

[18] Cf. Chap. 2.

[19] If personal importance of religion is seen as a continuum ranging (1) from complete submission to the expectations of one's church to (2) more or less complete independence of one's church, it is clear that in this distribution about half of the parents stand at the VI range of the continuum. With benefit of hindsight, were we to test this factor again, we would enlarge the number of categories in the scale, perhaps to four, in order to sort out religiosity differences within the present VI category and to produce a closer approximation to a normal distribution curve.

In this direction, Fichter has applied the following fourfold classification of Catholics: [*a*] "*Nuclear*, who are the most active participants and the most faithful believers. [*b*] *Modal*, who are the normal, practicing Catholics easily identifiable as parishioners. [*c*] *Marginal*, who are conforming to a bare arbitrary minimum of the patterns expected in the religious institution. [*d*] *Dormant*, who have 'given up' Catholicism but have not joined another denomination." J. H. Fichter, S. J., "The Marginal Catholic: An Institutional Approach," *Social Forces*, vol. 32, no. 2, pp. 167–172, December, 1953.

[20] It might be added that parents' religiosity also varies inversely with their socio-economic status. That is, the higher the SES level, the lower, on the average, is the religiosity reported. However, when both the SES and religious-group factors are analyzed simultaneously, religiosity varies more among religious groups within any given SES stratum than among SES strata within any given religious group.

More accurately stated, in all parental-SES strata such analytical control tends to eliminate the differences in religiosity distributions between Protestants and Jews seen in Table 16–5 and tends to magnify the distribution differences between each of the latter two groups and the Catholics. For example, in the parental lower-SES stratum the "very important" frequencies of Catholic, Protestant, and Jewish parents are 74.0, 39.8, and 37.5%, respectively.

[21] S. H. King and Daniel Funkenstein, "Religious Practice and Cardiovascular Reactions during Stress," *J. Abnormal Social Psychol.*, vol. 55, no. 1, pp. 135–137, 1957.

[22] Rev. E. E. Bruder, "Administrative Concerns in a Public Mental Hospital Chaplain Program," Academy of Religion and Mental Health, 1958, p. 3.

[23] It may be remembered that this expresses the number of Impaired cases per 100 Well respondents in a given group.

[24] Cf. p. 303 of this chapter.

[25] Roberts and Myers, *op. cit.*, p. 762.

[26] For the New Haven data on treated neuroses and character disorders see Table 16–1.

[27] Cf. L. Srole, "Social Conflicts in Relation to Health Education: Minority Groups," *Psychological Dynamics of Health Education*, 1951, pp. 90–99; M. Zborowski and E. Herzog, *Life Is with People*, 1952, pp. 114–115 and 354–357; and M. Zborowski, "Cultural Components in Responses to Pain," *J. Social Issues*, vol. 8, pp. 16–30, 1952.

[28] Rev. J. A. O'Brien, "Psychiatry and Confession," Paulist Press, 1948.

[29] Article in *L'Osservatore Romano*, Sept. 21, 1952.

[30] For calling these church developments to our attention, we are indebted to Amorita Suarez.

PART IV

Epilogue

CHAPTER 17 *Psychiatrist's Commentary*

Stanley T. Michael

This volume was written by sociologists and is based on sociological data gathered in a random sample of the community. But it is a sociological study with medical orientation. The central reference point is an estimate of mental health; its central theme the etiology of mental illness; its sociological concern the amount, quality, and adequacy of psychiatric treatment. Although conducted by psychiatrists and clinically oriented sociologists, the Study was not clinical. Subjects were not seen by trained medical personnel, nor were medical and laboratory examinations performed in a clinical setting. Nevertheless, the fundamental orientation toward psychiatric problems has resulted in a significant contribution to the psychiatrist who, bearing down on the individual case, may formulate only a general impression of the total social and epidemiological setting of his patient.

Not infrequently, the clinician recognizes psychopathology in relatives and other significant persons related to his patient. He may not know the extent of the psychopathology, but he does usually recognize that most of these persons have never had psychiatric care. How severe is this unknown psychopathology? What behavior is the psychiatrist to expect from these other untreated significant persons in relation to his patient? Can he treat his patient as though everyone else around him were mentally well? The clinician had to formulate pragmatic answers to these questions. He will have to continue to meet the impact of the environmental psychopathology on his patient. In this respect the findings of the Midtown Study can be of significant assistance by providing information not only on the prevalence of psychopathology in the community as representing his patient's broader environment, but also by estimating the frequencies of psychopathology in specific demographic situations and circumstances.

The design of the study provided for simultaneous estimates of treated and untreated psychopathology as well as the enumeration of known

patients in psychiatric treatment. The information was gained from two sources: the respondent himself and the treatment facilities—hospitals, out-patient clinics, psychiatrists in private practice and psychologists. Through this integrated approach, information about prevalence of clinical morbidity, previously available only from clinical studies, assumed a new dimension in its relatedness to the total psychopathology in the community. Not only are we beginning to recognize the distribution of treated and untreated psychopathology, but also the various conditions which were previously only vaguely implied or suspected of being related to psychopathology and treatment are becoming more clearly understood. Reference is here made particularly to the relationship between socioeconomic status and the prevalence of psychopathology and its treatment. The relatedness of attitudes toward psychotherapy and such sociocultural factors as socioeconomic status, religion, or generation-in-U.S. is an enlightening contribution.

The concept of sociogenesis of mental illness deserves special comment. In the discussion of the conceptual design of the Study in Chapter 2, it was suggested that mental illness is multidetermined; however, since such factors as constitutional predisposition, biological determination, and psychogenesis are not fully understood in their theoretical preconceptions, nor accessible as data pertinent to this particular study, it was decided to report and analyze only sociogenic factors. There is no intention to disavow or conceal the etiological importance of the nonsociogenic factors, but the influence of these would remain largely undetermined and open to speculation. As a consequence of the decision to cover only the sociogenic factors, the reader who is not mindful of the formulation and design of the report may be impressed with a sense of sociogenic overdeterminism. This impression is further strengthened by the fact that the manuscript was written by sociologists whose orientation pervasively influenced the terminology and structural composition of the language of the book. The selection and formulation of concepts to be analyzed, the data suitable for such analysis, the framework of presentation, the arguments relevant to the claims, the supporting data in the tables, the new hypotheses extracted, and the form and outline of the book were all contributed by the sociologists.

The proposition presented in Chapter 2 that sociocultural conditions may influence, aggravate, or cause mental illness is a plausible hypothesis and worthy of testing. The method of choice for this investigation consisted of description and enumeration of demographic variables which carried potential as etiological agents and of the determination of their statistical relatedness to mental health. In this report, as in other scientific investigations, cause-and-effect relationship was assumed if cause preceded effect in time. In the conceptual formulation, the mental health of the respondent (as represented by the psychiatrist's rating at the time

of interview) was considered the effect and therefore was made the dependent variable. Conditions reported by the respondents as preceding the dependent variable were assumed to be antecedent and therefore possessed of a potential for influencing mental health.

The caution and reservations necessary in the interpretation of pathogenic potential in a matter as complex as the etiology of mental illness imposes severe limitations on generalizations from the findings, especially if these should be interpreted as constituting the total information. The pitfalls involved in statistical correlation of two or several biological variables are numerous not only because of the nature of the biological phenomena themselves, which in their complexity pose formidable sampling impediments, but also because of the multiplicity of interpretations of the implied associations, which may be spurious even when statistical validity is beyond question.

The partial applicability and incompleteness of the sociogenic hypothesis may be best demonstrated by analysis of an example. It has been shown in Chapter 12 that parental socioeconomic status as an antecedent factor is related to the mental health of the offspring, the best mental health occurring in respondents whose parents were in the high SES groups, and relatively unsatisfactory mental health in respondents whose parents were of low SES. The inference is presented that "these differences [in mental health] were predominantly implanted during the preadult stage of dependency upon parents." If one chooses to be oblivious of constitutional factors, this hypothesis might be acceptable, cautiously as it is worded. However, there are other possible interpretations:

1. The parents of the upper-SES groups had good mental health, which was passed down to their children—our respondents—by inheritance of a constitution promotive of good mental health. In contrast, the parents of low SES had poor mental health, which was passed on to their descendants through hereditary predisposition to poor mental health. Such a hypothesis, not proved, nor necessarily exclusive of other factors, offers a satisfactory interpretation of the data based completely on constitutional heredity.

2. A second hypothesis, sociogenic in nature, might be derived from a biological hypothesis that living organisms tend to return to homeostasis and from deviation and pathology toward normal physiology. It is not the parents' low SES which is pathogenic in the direction of poor mental health; rather, respondents are born in all SES groups with equal potential for good or poor mental health, but the conditions in the families of high SES tend to favor the evolution of the positive potential in the offspring, which in the families of low SES remains unexploited.

3. The statistical correlation may be interpreted by still another hypothesis, as may be inferred from the data regarding social mobility and

mental health (Chapter 12, pages 222 ff.). It would seem from the data presented that respondents who are upward-mobile in SES have better mental health than respondents who are downward-mobile. Mental health, as represented by the Sick-Well ratios of the various socioeconomic groups, has a greater direct correlation with the respondents' own SES as compared with the SES of the respondents' fathers. This may be demonstrated by the steepness of the regression curve of the Sick-Well ratios correlated with the respondents' own SES, which is greater than the curve of the Sick-Well ratios related to parental SES (Figure 4). These two observations would seem to suggest the possibility that a respondent's mental health determines his SES. In other words, and in the terminology used in the design of the investigation, the SES of the respondent becomes the dependent variable and a consequence of the respondent's own mental health, which thus becomes the antecedent variable. The same would apply to the respondent's parents, resulting in the observed correlation between parental SES and respondent's mental health.

4. The statistical correlation between parental SES and the mental health of respondents could be interpreted also as contingent upon the fact that respondents' SES and parental SES are highly intercorrelated. Given that respondents' mental health is closely related to own SES as a primary phenomenon, then parental SES may be tied to the former by its own relatedness to respondents' current socioeconomic status.

It is not intended here to estimate the extent to which each one of these hypothetical factors contributed to the relatedness of SES and mental health, nor is it possible from the available data. However, accepting the premise established in Chapter 2 that this report will be confined solely to the sociogenic findings, we must never lose sight of the ever-present alternative interpretations which, even though indeterminate and unknown, may be potential modifiers of the sociogenic impact.

The association of increasing severity of mental symptomatology with increasing age of the respondents is a finding which must also be hedged with numerous qualifying, cautionary, and conditional statements. The age of the respondent was known to the rating psychiatrist. It would have been very difficult, indeed frequently impossible, to gauge the significance of certain symptoms without the knowledge of the age milieu in which the symptoms operated. The age factor was taken into account and was represented in the psychiatrists' rating judgments. If on statistical count the symptoms of the older respondents still averaged to be more severe and more incapacitating, it can be inferred that on the basis of symptoms alone, without knowledge of the age of the respondents, the mental health ratings of the older respondents would

have been even worse, as the respondents would not have been credited with the compensations with which they countered the insidious decline in health due to aging.

The possibility must not be overlooked that the symptomatology on which the mental health rating was based was not necessarily of the same quality in the various age groups. Part of the matrix which formed the basis of the rating scale consisted of psychosomatic symptoms and illnesses. By definition, psychosomatic conditions were rated as moderate symptoms and were not considered adequate to elevate the rating beyond the designation "moderate symptom formation," even though the psychosomatic illness might be in a terminal phase as, for example, hypertension complicated by cerebrovascular disease and hemiplegia, conditions which certainly interfere with life adjustment. However, the presence of a psychosomatic condition did not preclude a more severe rating if other symptom complexes so indicated.

In early adulthood, psychosomatic conditions are not necessarily taken seriously. In contrast, the impact of recurring incidence with age, the unrelenting progress of relapse and remission, the chronic and increasing residues after each attack, as for instance in arthritis, impresses on the older respondents the extent of their incapacity, which in turn is more readily reported to the interviewer as age increases.

Psychosomatic symptoms increase with advancing age and no doubt contributed substantially to the more severe average mental health ratings in the groups of more advanced age. The prevalence of respondents whose psychosomatic symptoms were considered to be primary contributors to the mental health rating, outbalancing all other symptoms, and who were consequently designated as psychosomatic types was 5.2% in the age group 20 to 29, 11.8% at 30 to 39, 11.6% at 40 to 49, and 17.9% at 50 to 59. While undoubtedly change in role function, especially that of a parent respondent in relation to growth of children and their departure from the home, may contribute to conflict and stress and to the development of psychopathology in the older age groups, decline in biological vitality with concomitant loss of ability to cope with adversities, increasing physical debility, and illness cannot be disregarded as significant determinants of the increase in mental symptomatology observed in the respondents of advancing age.

There is, in addition, the question of differentiation of the types of psychiatric symptoms according to age level. Is there a difference in the quality of symptoms in respondents of the youngest age group as compared with those of the oldest? Reports attesting to a high incidence of neurotic symptoms in the twenties with steeply falling curves in the next decade[1, 2] raise the question whether the greater morbidity of the older age groups may not be based on symptoms of a more severe quality,

perhaps even psychotic, in addition to the already mentioned psychosomatic symptoms. The problem of the quality of symptoms as related to age raises a challenging issue for future research.

The higher incidence of psychosomatic conditions in the older age groups of the community sample leads yet to additional speculations in relation to psychiatric therapy. The more advanced medical clinics accept psychotherapy as the treatment of choice in psychosomatic conditions. However, the populace in general is more likely to consider its psychosomatic conditions physical and seek treatment with a general practitioner or a specialist in internal medicine. Indeed it has been estimated that 30 to 60% of patients seeking medical help for presumed medical conditions[3] are essentially afflicted with psychosomatic or psychoneurotic illness and consequently should receive psychiatric treatment. If the proportions of our respondents who had psychosomatic conditions increased with age, is it not possible that these respondents are receiving therapy for their psychosomatic conditions from general practitioners and other medical specialists? If so, our statistical evaluation, which indicates that respondents of the older age group are receiving less psychiatric therapy in relation to their need than do respondents of the younger age groups, may have to be reevaluated by further investigation. These respondents may be in a therapeutic relationship which, though ostensibly consisting of medicinal and physical therapy, is basically psychotherapy in disguise in the form of relationship therapy, directive encouragement, and supportive therapy. The presence and importance of such nonspecific, auxiliary psychiatric therapy must not be underestimated, even though from the viewpoint of the psychiatrist such treatment may be deemed inadequate because of its inability to provide understanding of the psychodynamic causes of the illness.

There are still other considerations which may contribute to the interpretation of the abrupt decline in rate of out-patient therapy in the older age groups of our respondent population. As has been cited,[4] the national annual frequency of chronic somatic disorder increases from 9.4% of the age 20 to 24 population to 31.1% of the age 55 to 64 population. The rate of somatic illness increases threefold from young adulthood to late middle age. Not only does frequency of illness increase with age, but so does the severity of incapacity resulting from such somatic illness. In youth somatic illness is not the rule and is not usually anticipated as a source of interference in life adjustment. It is also overcome with reasonably assured expectancy of early recovery because of the relatively vigorous physiological defense forces of the young patient. In contrast, with advancing age somatic illnesses, especially those with a chronic and recurring course, become increasingly important as a factor around which the patient must modify his life. Indeed, lapses in con-

formity in social behavior which would be ill tolerated in young adults are readily excused in the aged if attributable to somatic illness. Both the patient and society are apt to seize on somatic disability for explanation of social malfunction rather than dwell on psychoneurotic interpretations. Since the emphasis shifts with age to somatic disability, which in its own right is increasingly more threatening to social and even physical survival, it is likely that the resources, time, and effort of the patient will be preferably oriented toward somatic therapy rather than psychotherapy.

The data presented in this volume seem to be unequivocal in their indication that certain demographically defined groups of the population are influenced for or against psychotherapy by sociocultural factors. Age is essentially a somatic factor grossly related to somatic development and illness. But in our study it is also a sociocultural factor, especially in relation to psychiatric therapy, as the era of psychotherapy is relatively recent, and the older age groups have not been exposed to its impact at a time when their emotional pliability might have allowed for its acceptance. It would seem that with the sociocultural influences established as factors affecting the quest for psychotherapy in the various age groups, the next step for investigation is the unraveling of the complex relationships between age, sociocultural factors, and somatic illness—all these bearing on psychiatric symptoms and their treatment by psychotherapy.

The uncovering of mental and emotional symptoms in four-fifths of the sample representing an urban population suggests that either a degree of psychopathology is the norm in the statistical sense of population average or that mental mechanisms which by psychodynamic derivation can be considered pathological may be a mode of normal adjustment.

The individuals in the Impaired category of mental health, derived from the original psychiatric ratings containing the suffix "with interference in life adjustment," are represented as being analogous to patients in psychiatric therapy. Such a designation clearly demonstrates the difficulty in dissociating the hitherto clinical approach to mental health from concepts necessary or desirable for the estimate of mental health in a nonpatient community population. When it is urged that the mental ratings "Marked" and "Severe" are comparable to the clinical conditions of patients in ambulatory treatment, and the rating "Incapacitated" to the clinically hospitalized, the distinction is presented only as an attempt to anchor our conceptualizations in relation to known degrees of psychopathology.

If the degree of severity of psychopathology in the above ratings of the community sample is comparable to that of patients, what are the

factors which sustain these respondents in the community and prevent them from succumbing to the load of symptoms which drives their peers into ambulatory treatment or a hospital? Do the symptoms of these untreated respondents have an unusual protective quality? Do these respondents have compensatory devices which counteract the pressures of the symptoms? Are they equipped with special, socially motivated assets or symptoms which prevent them from seeking therapy? A well-organized defense mechanism, a systematized paranoid state, or a devotion to a system of physical culture or to a religious healing cult may possibly be sustaining individuals with large loads of psychopathology in the community. On the other hand, passive-dependent tendencies; depressive, hypochondriacal, or hysterical symptoms; or introspective rumination may incline others to collapse of defense and to the seeking of therapy. The number of symptoms or their severity may provide an indication of severity of psychopathology, but the degree of interference in life adjustment or the appearance as a patient for psychotherapy are determined also by a socially directed quality of the symptoms in both their positive and their negative senses.

The proposition that those in the Impaired mental health category are in risk of needing help evolved during the analysis of the data. It was not one of the criteria in the original rating process—indeed no estimate was made of the need for therapy of the respondent during the rating process. It may not have been possible to estimate the need for therapy from the data available to the rating psychiatrist, but this investigation does indicate that it is desirable that any future study of psychopathology in an untreated community population be designed to provide more definite answers on the need for therapy, the desirability of therapy, and its acceptability to the respondent.

The data and interpretations reported here are committed in the direction of revelation of etiological relationships between selected demographic variables and mental pathology. As the data evolved, we learned too that certain demographic variables influenced attitudes of the respondents toward psychiatry and psychotherapy. Undoubtedly psychopathology and demographic variables also influence the respondents' attitudes which are related not to psychiatry directly, but rather to all social interactions and ultimately to the structure of the social order itself.

Psychopathology is destructive to the individual and may interfere in his enjoyment of life. Psychopathology of the individual may also interfere in the lives of others. In order to understand and cope with these noxious forces with adequacy and appropriateness, we must know more about them. This volume is intended as a contribution toward that needed understanding. The data presented provide new knowledge and

a springboard for future research in social psychiatry, and hopefully will lead to the redefinition of some of our psychiatric concepts and insights.

FOOTNOTES

[1] M. Shepherd, "The Epidemiology of Neurosis," *Intern. J. Social Psychiat.*, vol. 5, no. 4, p. 276, 1960.

[2] M. Shepherd and E. M. Gruenberg, "The Age of Neuroses," *Milbank Mem. Fund Quart.*, vol. 35, no. 3, p. 258, 1957.

[3] R. Kaufman et al., "Psychiatric Findings in Admissions to a Medical Service in a General Hospital," *J. Mt. Sinai Hosp.*, vol. 26, no. 2, pp. 160–170, March–April, 1959.

[4] S. D. Collins, K. S. Trantham, and J. L. Lehmann, *Sickness Experience in Selected Areas of the U.S.*, Public Health Monograph, 1955, pp. 8–21.

CHAPTER 18 *Sociologist's Sight Lines: Retrospective and Prospective*

Leo Srole

From inception a long-range research venture, like an expedition to an unscaled mountain peak, has eyes on a distant point of revelation and feet on stony realities. Inherent in such an undertaking is not only a large commitment of human careers, but also innumerable risk-laden decisions, and overhanging all, an outcome shrouded in uncertainties.

Looking back afterward, chronicle asks to be made of the course of developments as the investigation picked its way uphill toward terminus. Such an autobiography of research, rarely attempted heretofore, is far beyond our purposes and our powers. However, in the retrospective vein of the present chapter, we might at least mark certain turning points in the life history of the Midtown Study.

With Rennie newly occupying a research director's chair, the Midtown team began to assemble on June 1, 1952; and early that fall it moved into the preliminaries of planning. By November, 1953, it had shifted into the high-gear stage of gathering information,[1] a phase that did not slacken in tempo until the following July (or terminate until five years later). Launched next were large and complex operations in record checking; processing and classification of perhaps one million items of information; evaluation of 1,660 interview protocols by two psychiatrists; design and completion of a systematic data-extraction program, entailing many thousands of machine cross-tabulations and computations, etc. By early 1956, it was possible to commence the slow sifting and assessment of the massed data[2] and, most demanding of all, to start orchestrating them toward the volume in its present finished form.[3]

Untimely death came to Thomas Rennie in May, 1956, near the Study's fourth anniversary. He had lived to approve the original chapter outline of the book, to write its introduction, and to read several other chapters in first draft. Successor to his Cornell posts was his long-time friend and associate, Alexander H. Leighton. Under the latter's skilled

and patient steersmanship, preparation of this volume proceeded until completion of the third and final draft, in 1960. Although heavily beset with his own prior research responsibilities, Leighton made it possible for us to develop this book within sight of its circumscribed potentialities and to substantially refine our own thinking as we synthesized and integrated its contents.[4] To Professors Rennie and Leighton we here inscribe our profound debts for their supportive roles as partners in this difficult scientific venture. We record special gratitude to our colleague Stanley Michael for his careful reading of manuscript in its several stages. The final draft of this book has also profited from the close reading and commentary of Dr. Oskar Diethelm.

Some readers will have reached this far point in the volume through the technically demanding route of the preceding data chapters. Others perhaps will have come here directly from the book's introductory Parts I and II for a compact overview and evaluation of findings. The present chapter of summary takes the form of an epilogue, so to speak, drawn from the perspective of the Study's senior social scientist to whom Rennie had delegated major responsibilities for the Study's key research operations and for preparing this monograph.

THE APPROACH

The Midtown Study stands on one front of research among several in the recently opened and largely unexplored field of social psychiatry. The special ramifications of this field were intimated in the following statement of Fillmore Sanford[5] before the House of Representatives' Subcommittee on Health and Sciences:[6] "Mental health is not exclusively a psychiatric problem, or a psychological problem, or a taxpayer's problem, or a legislative problem. It is all of these and more. It is a problem of the whole social fabric. In looking at it we would do well to employ for all they are worth the trained eyes of those accustomed to working from broad perspectives—the anthropologists, the social psychologists, the sociologists." [7]

From the converging perspectives of medical epidemiology, clinical psychiatry, and these social sciences, under the impetus of urgent action and basic research needs, the present investigation fixed its sights on large goals that required several kinds of research programs.

One implementing program provided a synoptic portrait of Midtown as a residential section near the turbulent center of New York City's rampant economy. Sketched were the consequences for this area of a population density probably unmatched anywhere beyond Manhattan and of the kind of massive housing, compressed horizontally and overextended vertically, that alone can make such unparalleled density possible.

Drawn also in profile was Midtown as a population, presenting such typically metropolitan features as the socioeconomic gamut from extremes of wealth to depths of poverty, considerable ethnic heterogeneity, and marked religious variety. Likewise characteristic of the American metropolis are the area's heavy representation of unmarried adults, with an excess of females in particular, its large number of working wives, and its scarcity of children. Although deviating from the City's four outer boroughs, Midtown in these and other demographic respects was found to be a close counterpart of Manhattan's 1950 non–Puerto Rican white population, numbering some 1,400,000 people.

Of course, there is a minority view, with the Chicago *Tribune* its major voice, holding not only that America ends at the Hudson River, but implying also that Manhattan is an island lying somewhere between the Palisades of New Jersey and the Cliffs of Dover. Regional humor aside, Midtown as a community may represent a high point in the evolution of Western urbanization, but it is also of the warp and woof of America near the middle of the twentieth century. As such, the ills prevailing among its people conceivably may also prevail little differently across much of the nation's urban landscape—from Newburyport, Massachusetts, to Muncie, Indiana, to Manhattan, Kansas (1950 population: 19,056), and beyond. By way of an alternative to contrary preconceptions, this point is emphatically an open empirical issue still to be settled by future investigators.

The final details in this group portrait were applied to weigh Midtown's qualifications as a full-fledged community. Though in certain respects Midtown's human needs seem to be well met, in other ways they are rather less than adequately served. Specifically, a series of somatic and behavioral pathologies, found heavily concentrated in Midtown's long-condemned slum housing, highlighted the area's apparent failure to sustain effective, broad-based central institutions of the voluntary citizens' council type. On this evidence, Midtown contrasts with several other Manhattan areas in falling short of stature as a fully responsive problem-solving community.

All in all, from the chapters presenting Midtown in portraiture there can be no question about the enormous complexity in its features as a physical habitat, in the demographic architecture and origins of its population, and in its sociological and psychosocial qualities as a human collectivity.

To this most complex of communities the Study frontally directed two major research programs. Toward the goal of tracing the population sources and treatment destinations of psychiatric patients, our Treatment Census operation on a given day counted 2,240 Midtowners in the care of mental hospitals, clinics, and office therapists. Given larger and deeper reach, the Home Interview Survey by face-to-face

encounters studied 1,660 previously unknown resident adults representing an accurate cross-section sample of their population universe. With these two operations the Study is one of the exceedingly few investigations to have attempted a double epidemiological "fix" on both the sick and the well, and among the sick, on both the treated and untreated.

Through the Home Interview Survey the Midtown researchers chose primarily to probe toward the obscure and tangled roots of mental health differences, one of the most refractory of life-science problems. Narrowing the search to manageable proportions, the survey sought traces of sociocultural forces that directly or indirectly have benign or malignant mental health impacts more likely to be discerned in the bird's-eye perspective of a sizable community population. We assumed that first approach to the locations of these forces could be made through the demographic factors which subdivide the community into a network of differentiated groups.

These demographic factors were ordered in terms of the following fourfold scheme, in which the point of reference is the individual adult under study:

Demographic Factor Types

	Independent	*Reciprocal*
Biosocial	1. Age 2. Sex	1. Marital status
Sociocultural	1. Parental SES 2. Generation-in-U.S. 3. Religious origin 4. Ethnic origin	1. Own SES 2. Rural-urban background 3. Own religion

The Home Survey placed major emphasis on the above 10 demographic variables and, as a particular innovation, on the four independent factors of sociocultural type which, for our sample adults, were main axes of their childhood family environment. More specifically, these variables were conceived as criteria for discriminating different kinds of natal family constellations. In our current version of a generally accepted view, the natal family unit is the arena where parental behavior tendencies, operating as levers of the family's encompassing groups, exert decisive weight on the future mental health chances of its offspring.

The second point of innovation in the survey's strategy may be seen in its mode of demographic analysis. With few exceptions, previous epidemiological studies in mental health had embraced only one or two demographic factors. To be sure, there is intrinsic interest in mental morbidity differences among the several subgroups that define a given

single demographic variable. This interest was routinely served in each of our data chapters. However, the demographic factors are variously interlocked with each other. In this light, a modest correlation between factor Q and mental morbidity may be altogether a spurious consequence produced by Q's own dependency on factor R. Accordingly, it has been our procedure to test progressive *combinations* of the independent demographic factors for the partial relationship of each, while relevant others are controlled, to mental health as the consequent or dependent variable. Such multivariable analysis could be carried only within the limits allowed by the given size of the adult sample studied.

The Midtown investigation, beyond any question, was large in focus, goals, strategy, and operational scope. To be sure, there are social scientists in the mental health field who prefer the research strategy of a "multitude of limited-aim studies [involving] relatively small steps." [8] However, intensive study of small numbers of "captive" patients and the panoramic investigation of a community's population at large serve different purposes that arise from different kinds of problem formulations and issue in different orders of generalization. In the end, both types of research perform potentially important feedback functions for each other,[9] suggesting at the very least that each is partially justified by the limitations of the other.

If the Midtown Study was expansive in certain dimensions, we hope this report has been appositely restrained in its claims for the findings here presented. First to be made explicit is the fundamental position, given most recent expression by Nobel laureate Bridgman,[10] that "it is in the nature of knowledge to be subject to uncertainty. . . . In the end, when we come to the places where human weariness and shortness of life force us to stop analyzing our operations, we are pretty much driven to accept our primitive [research] operations on the basis of a feeling in our bones that we know what we are doing."

Beyond this "what do we really know" level of epistemology, an investigation of this kind must be alert to potential errors that lurk at every step. In the planning stage of the Study all errors that could be anticipated were identified. If they could not be avoided, then if possible, procedures were built into the research design allowing subsequent estimates of their effects. And if this was not possible, the source of potential error was so to speak labeled *caveat emptor* in Study reports, where vigilance was also maintained to detect the intrusion of unanticipated errors. Even so, when humans study humans, it is not likely that every possible source of error can be identified.

Except for uncompromising rigor in methods of designing and executing sample selection, statistical trappings implying precision of results were kept to a minimum. Particularly emphasized was the inescapable crudity in certain Study variables, above all that of mental health among

our sample adults. On this issue, pivotal to the entire investigation, Rennie took a decidedly conservative position. He held that neither the "signs and symptoms" information secured in the sample interview, nor the conditions under which the Midtown psychiatrists reviewed and evaluated these data, permitted well-grounded discrimination of clinical syndromes; therefore, it was not possible to apply the standard diagnostic classification of mental disorders[11] to our sample adults on a systematic basis.

In addition, Rennie knew that his system of classifying gradients of symptom formation carried its own set of inherent limitations. As in a clinic, the psychiatrist's task was one of evaluating in its entirety the sizable body of relevant evidence gathered about each sample respondent. Representing one variant in a universe of permutations and combinations, each individual cluster of information items called upon the psychiatrist to weave an extremely complex set of discriminations into a single net judgment. Operating doubtless in this subjective process were some idiosyncratic elements related to the psychiatrist's own combination of professional training, clinical experience, theoretical leanings, personal sensitivities, selective inattention, and the like—some rooted in levels of perception and cognitive synthesis probably beyond his own reach for explication. Thus, the series of mental health categories used to divide the Study's dependent variable, far from being a firmly delineated yardstick, was essentially a crude heuristic scale devised to structure the psychiatrist's refracted judgment in an ordinal manner.

However, it was Rennie's further premise that the weight of the idiosyncratic elements operating in each judge would be considerably reduced by definitively assigning each respondent to a mental health category determined by systematically balancing the two evaluating psychiatrists' independent judgments.[12]

Let us make appropriate allowances for the above departures from perfection,[13] including the "we think" and "we believe" hedges that are to be understood as surrounding all findings reported in our data chapters. Yet when these are intuitively weighed in the scale of critical judgment, we are left—as Bridgman phrased it—with a "feeling in our bones" that the Study's findings do not fundamentally misrepresent the facts of life in Midtown.[14]

This inference may seem unscientifically compounded with a dosage of faith, as indeed it is. In any case, both the investigators and their critical readers can look beyond the ready counsels of perfection to the ultimate arbiter of all scientific disagreements, namely, the bar of other research, past and future. To that end, it has been a consistent effort of this report to place our data in the critical perspective of the most relevant collateral evidence that we could uncover.

A final note to be registered is that even with firm knowledge about

mental health in the population studied, such data in their basic research aspects—as against their social policy implications—would still be seen primarily as temporary scaffolding for constructing new or more focused hypotheses as guidance to future investigations in other communities.

THE HOME INTERVIEW SURVEY: MENTAL HEALTH IN THE MIDTOWN SAMPLE AS ENTITY

In mental health terms, what can be summarily said about the way things look to us in Midtown? As formulated in the Study, one part of this question concentrated exclusively on the professionally visible sick of all ages and their selective flow through the bottlenecks of the several kinds of local psychiatric facilities. Data answering this particular query, drawn from both the Treatment Census operation and the morbidity cases uncovered by the Home Interview Survey, will be summarized below.

The second part of the large question concentrated on the age 20 to 59 Midtown population as examined by the methods of the Home Survey operation.

Placed individually against the psychiatrists' gradient scale of symptom formation, the sample population of Midtown adults conveys a composite group profile of mental health. Standing at the most favorable extreme are the Well, satisfying the norm of freedom from significant symptoms and accounting for under one-fifth (18.5%) of the sample. The Mild and Moderate levels of symptom formation, presumably covering the subclinical range of the spectrum, comprise 36.3 and 21.8% of the sample, respectively. These, then, are the two most populous categories in the psychiatrists' scheme of mental health evaluation, offering intimations of the latent, prodromal pathology lying endemic in one of the most favored of communities.

The Marked, Severe, and Incapacitated grades, in Rennie's view jointly spanning the morbidity or clinical or Impaired range of the mental health continuum, hold sample segments of 13.2, 7.5, and 2.7%, respectively, or 23.4% all told. Here we take the measure of pathology that seems to have halting, laming, or crippling effects on personal performance in one or more social theaters of adult life.

Compressed into a single sentence, the subclinical forms of symptom formation aggregate almost a 60% majority of the sample adults, and on either side of this modal group are the segment of Well individuals, approximating almost 20% of the sample, and the segment of Impaired people, representing somewhat more than 20% of the sample.

The mental health composition thus delineated in the Midtown sample population would acquire an added dimension of significance if it could be compared with other urban community populations as whole social units. Unfortunately, no other urban study published at the date of this

writing has reported on the frequency of wellness or of subclinical forms of symptom formation, ruling out comparative analysis on these levels. However, several investigations have reported on the over-all (untreated and treated) frequency of mental disorder, and these offer at least the potentiality for comparison with the Midtown morbidity findings.

Such comparison was especially indicated, given that previous studies of patients, i.e., treated morbidity only, could seem to imply that the Midtown over-all morbidity rate was inordinately high. If so, one ready interpretation might be that the assessment "screen" applied by the Midtown psychiatrists to identify the Impaired individuals had been unduly coarse.

Seeming to support this view were investigations of over-all mental morbidity prevalence in two Eastern metropolitan populations, namely, Baltimore and Boston. Both of these studies reported over-all morbidity rates of about 11%, representing a large divergence from the Midtown sample's rate of 23.4%. Suffice it to recall that the Baltimore and Boston rates can be shown to rise to approximately the Midtown sample's frequency when estimates of certain known gross errors in underreporting mental disorder cases are made and applied as partial corrections, after certain differences in population composition have been adjusted.

However, if these corrected illness rates from Baltimore and Boston do not stand as a challenge to the credibility of Midtown's estimated impairment frequency, neither can they be read as lending support in any way to the plausibility of the Midtown estimate.

The basic fact is that after all correctable adjustments are made toward achieving comparability in certain specific details, the three metropolitan studies fall short of comparability in too many other vital respects. We need not review all these interstudy variations here, but certainly the most critical center on differences in methods of psychiatric examination and classification of their sample members.

This is a difficulty that is not specific to the three studies under discussion. Instead, it reflects a general predicament that concedes comparability of morbidity rates reported for different populations only when they are studied by similar methods, covering a kindred battery of individual information, which is classified in terms of cognate categories.[15] Even so, if different psychiatrists should apply such categories, the element of divergences in clinical judgment and nosological usage interpose their own refractive barriers to inter-community comparisons. Thus, the Midtown sample's 2:6:2 distribution among the Well, the subclinical, and the Impaired bands of the mental health spectrum was tentatively considered specific to *this* sample population as screened through the particular methods, data, and psychiatric judgments brought to bear in the present investigation.

THE HOME INTERVIEW SURVEY: INDEPENDENT DEMOGRAPHIC VARIABLES AND THEIR LIMITATIONS

To tailor research plans to the realities of his technical resources and his time and money budgets, the investigator must firmly, and often arbitrarily, shut out certain relevant orders of phenomena from his study design. In this simplifying process, he may slip into implicit assumptions that will later rise to demand a critical hearing.

A case in point is the taxonomic classification of demographic variables outlined above. In formulating this scheme, the writer had placed special emphasis on the potential significance of the independent factors of the sociocultural type, with their space-time locus in the adult's family environment during his childhood years. Appearing to be beyond the choice or influence of one's personality processes during childhood, each of these variables was hypothesized as representing one *input* cluster of patterned family conditions, among all other potential *input* conditions, to which adult mental health may stand as an *output,* or end-result reaction. Here it was assumed, in short, that the varying demographic alignments of natal family units might offer clues to differences in intrafamily functioning, differences significant for the later mental health development of their offspring.

Peripheral in this observational framework were larger spheres of social phenomena that had operated on the adult's childhood family in various complex ways. In neglecting to take due account of these spheres we had overlooked the forces of social change operating along the dimension called *history.* In effect, if not by intent, the analytical model implied by our foreshortened historical focus was that of childhood families firmly embedded in their multiple group matrices, all within an encompassing social setting that was relatively stable in character. In point of fact, needless to say, Americans have been and continue to be a "people in motion." [16] They have moved overseas or overland; and they have moved from smaller places to larger ones and back.

This vast churning of peoples hardly conforms to the static population model unwittingly implied in the original formulation of the independent demographic factors. For the latter, clarity of their independence is now qualified by this fact: Whether the individual stayed on in the childhood home town or departed and whether one migrated to Manhattan or elsewhere were options that few could altogether avoid. We can plausibly assume that the decision taken on these options no doubt depended in some part on personal qualities and processes of self-selection. Even for a factor so far beyond self-selection as sex differences, our findings must carry the cautious proviso that they apply to men and women of the kind who elect to live in places like Midtown.

Of course, this qualification, attached to all the Study's demographic groups, is of a kind that is spread far across the decidedly dynamic American society and its peripatetic people.

THE HOME INTERVIEW SURVEY: INDEPENDENT DEMOGRAPHIC TEST FINDINGS

We have emphasized that over-all mental morbidity rates separately derived in two communities often stand on questionable grounds of comparability, in part because of technical or judgmental differences between the two investigations. However, the researcher's comparisons of demographic groups within his *own* study population do not face this particular difficulty.

From this fact emerges an important derivative. That community A has a reported morbidity rate of 15% and community B one of 20% is a difference that may largely be an artifact of procedural disparities between the two studies. However, let us assume that in *both* communities the unmarried adults as a group happen in actual fact to be sicker than are the married. The investigator in community A, let us say, reports morbidity rates for single and married of 20 and 10%, respectively, whereas from community B the other researcher reports rates of 26 and 14% for his corresponding groups. Thus, both investigators will have detected the extant *relationship* between marital status and mental morbidity. This concurrence would come through despite their technical divergences, because to his local single and married groups each had applied the *same* methods and criteria.[17]

It is apparent, therefore, that in such studies of community demographic segments the *specific* numerical values of reported morbidity frequencies are not of decisive moment. Instead, the *direction* of intergroup differences in morbidity rates is at the heart of this significant question: Is there a consistent correlation between the given demographic variable and mental health composition? It follows, then, that in serving this criterion, associations uncovered in two competent investigations can be cautiously and perhaps fruitfully compared *despite* accompanying differences in methods.

These observations, in turn, may have two other implications. First, for purposes of the above criterion, freedom to generalize from the Midtown findings cannot be restricted solely on grounds of the special technical nature of the mental health yardstick applied in this Study. Second, for checking on these Midtown linkages we can draw on demographic results uncovered in other communities by instruments rather less than identical. Accordingly, the data chapters in this volume were designed to take careful account of relevant published studies that throw light on the association, let us say, between sex difference and mental

health in other kinds of communities or general populations. Obviously, if this Midtown linkage is paralleled in the findings of other investigations, then its seeming anchorage in the studied Midtown men and women is potentially lifted to another plane. This is a plane in which the relationship discovered is probably no longer specific to Midtown but perhaps more general to larger spheres of American society. How much larger depends, of course, on the scope of such collateral studies. In the absence of such collateral evidence, on the other hand, we lose freedom to generalize from our data but retain the option to elaborate hypotheses about them.

Perhaps the paramount emergents from the preceding chapters were the findings that respondents' SES origin and age share a separate but mutually reinforcing input relationship to frequencies of both mental morbidity and wellness among Midtown's sample adults.

Such a triangular complex is inherently more difficult to circumscribe than is a simple two-factor link. Yet this specific triad continues to come through in consistent fashion when three collateral sources of age-fragmented evidence are pieced together. One is based upon psychiatric observation of the national college population universe (age 18 to 22). The second emerged from a large cross-section sample of American enlisted men in the age range 18 to 37. The third derived from the Bellin-Hardt investigation of aged people (over 64) in an upstate New York city. In effect, therefore, the Midtown Study, covering the widest age span of all, together with these three highly contrasting sources of evidence, suggest that the triadic constellation of SES origin, age, and mental health may well be a generalized and, to judge from the Army sample, perhaps a national phenomenon.

Testing the sex factor revealed no mental health differences between the inclusive male and female groups in the Midtown sample. This "null" finding persisted when the analysis was narrowed down to mental health differences between men and women of like age, SES origin and generation-in-U.S.

Here we have a quadrangular analytical complex. The only other investigation of a community sample with like substantive coverage was that of Bellin and Hardt. Applying analytical controls similar to ours (age, own SES), their analysis also yielded no sex differences in morbidity as defined by their criteria of eligibility for hospitalization. Since the Bellin-Hardt study in over-all research design is a relatively close approximation of the Midtown Home Interview Survey, this parallel finding suggests the possibility that the mental health similarity in the two sexes is not peculiar to Midtown and may well be a more widespread urban phenomenon, at least in New York State. Earlier community studies elsewhere, technically cruder and lacking SES controls, in some instances reported evidence supporting this "no difference"

finding and in other cases contradicting it. Thus, how generalized is this sex similarity in the American population at large remains for future determination.

By "religious origin" of the Midtown respondent we mean the faith in which his parents had been reared. Sorting the sample on this criterion, we found that the Protestants present a more favorable mental health picture than the Catholics, and the Jewish group has the most favorable of all. However, when SES origin and age are standardized, Protestants and Catholics emerge quite similar in mental health composition. The Jews, by comparison, retain a heavier concentration in the subclinical Mild-Moderate range of the mental health spectrum and a significantly lower Impaired rate. The latter margin of difference is almost entirely accounted for by the smaller proportions in the Severe and Incapacitated classes at the extreme end of the Impairment range. Moreover, this divergence is most pronounced among Jews of lower (E–F) parental SES strata, where the other two groups appear with their largest impairment rates. No other community studies are known to bear substantively on religious groups in relation to such an over-all mental morbidity measure. In strict terms, therefore, these findings must provisionally be considered specific to the Midtown religious groups. However, the data on the Jews seem to find a meaningful echo in the religious differences reported by epidemiological studies of alcoholism and suicide. Such investigations have consistently shown the relative infrequency among Jews of these behaviors, which are symptomatic, in Rennie's terms, of extreme mental health impairment.[18] This seeming consonance of evidence considerably enlarges the chance that the mental health trend exhibited by the Midtown Jewish-origin group may be a general, rather than a purely local, phenomenon.

Respondents could not select or influence their parents' socioeconomic status, their own age, their own sex, or their parents' religious upbringing. By definition, then, these demographic factors must necessarily have varied through processes in which respondents' mental health had little or no part. It is in this particular sense that we have accepted these variables as being independent in relation to adult mental health, the Study's dependent factor.

We had assumed that the generation-in-U.S. variable was of this broad character, at least for the American-born segment of the sample population. The situation on all generation levels proved to be considerably more complicated than we had uncritically assumed. Proceeding analytically through the generation sequence from I (immigrants) through IV, we had hypothesized, would reveal progressively better mental health composition. Instead, our data suggested that few mental health differences existed among respondents of the four generations who were of like SES origin and age.

Dissection of this unexpected finding and what produced it exposed our failure to consider the turning-point consequences of the congressional acts of 1921 and 1924 in restricting the number, provenance, and eligibility of immigrants. These acts not only interposed a mental health screening of prospective immigrants, but also diverted their main flow, previously from the more rural and lowest-SES reservoirs of Europe's population, now from the more urban and higher-SES watersheds.

Our Midtown sample immigrants were indeed largely post-1921 in their arrival here. Nevertheless, among them we were able to isolate two extreme types, corresponding to the older (O) and newer (N) population reservoirs just mentioned. Both types were of course predominantly self-selected; and both with few exceptions had also been screened through the overseas visa-review apparatus of the United States government. With the crystallized forms of mental disorder and the more marked illness risks largely sifted out, by subjective and objective processes of selection, both types of immigrants almost certainly were far more homogeneous in mental health composition than were their native populations. Thus "purified" in the same direction, it might be assumed that on arrival the two types did not differ radically from each other in mental health respects, or at least differed less than we might expect from their divergence in parental SES.

With standardization for age differences, the type N immigrant (urban, "middle"-SES origin) emerged with an Impaired-Well ratio actually somewhat better than those of U.S.-born generations II and III. On the other hand, type O immigrants (rural, "lower"-SES origin) yielded a Sick-Well ratio far larger than that of generation I as a whole. Thus, had type O been in the majority among our generation I group, as it had been in the pre-1921 immigration waves, the peak morbidity concentration originally hypothesized for this group would surely have appeared.

That the three U.S.-born generations of like age and SES origin showed no mental health differences also contradicted expectations. Furthermore, we had originally defined these three generation positions as imposed by descent and therefore beyond the influence of personality processes. From the Midtown sample we ultimately learned that these U.S.-born generations are variously entwined with the factor of in-migration from the nation at large. Such in-migration is often psychogenically determined, and if so, differential subjective selection may obscure the generation trends. This seemingly turned out to be the case. Among New York–born-and-bred respondents, the generation II and III–IV groups differed in Sick-Well ratios in the manner originally hypothesized. Among in-migrants of the same generation groups, on the other hand, the intergeneration difference, for reasons we can only speculate about, was reversed, thereby offsetting the New Yorkers' trend.

Midtown data from the generation groups among native New Yorkers and from type O immigrants, extricated as they were from the separate cross-current effects of rural-urban movement, now seem to stand in support of our over-all generation-in-U.S. hypothesis as originally formulated.

However, we are not aware of any other general population study conducted with the generation variable, so dissected, in its focus. Lacking collateral evidence that might bear on the generality of the evidence reviewed, we must in all rigor insist that the data supporting our generation hypothesis are as yet specific to Midtown-like populations and accordingly are of unknown general significance.

The national-origin factor, as confined to generations I, II, and III, also had been considered a demographic variable of the independent, sociocultural type. With the selection processes of immigration and in-migration engulfing the generation variable, the independence of the ethnic factor is likewise placed in question. In any case, of the seven ethnic subgroups isolated in the immigrant generation, only three stand out in mental health composition as deviant from the rest. For two, the differences seem to be explained by their special "loadings" of type O and N migrants. This explanation accounted for little of the striking deviation in mental health composition revealed in the sample's small Puerto Rican group, allowing us only to speculate about the factors responsible.

Here again we lack collateral data bearing on mental health in ethnic groups elsewhere on the national scene. Accordingly, the generality of our finding that no relationship exists between the national-origin and mental health factors (apart from the age, SES origin, and O–N typology) must be considered an open question.

THE PATIENT TRAFFIC: LOGISTICS AND GENERALIZATIONS

Before proceeding to assay the above Home Survey findings for hypotheses that may conceivably help to account for their direction, we might briefly review the phenomena to which our Treatment Census operation in particular had addressed itself. Our interest has been in two different facets of the patient traffic. The first has to do with the demographic sources and institutional destinations of those who have found their way to psychiatric attention. This we call the "logistic" problem, to which we shall return presently.

The other aspect is the logical problem adhering to generalizations drawn from file data by enumerative studies of mental patients, principally those hospitalized. An incomplete inventory of investigations reported in English language publications listed 55 of this kind that had appeared between 1929 and 1954.[19] With exceedingly few exceptions, these investigators took the characteristics of their patient aggregates as

more or less accurately reflecting the characteristics of the psychotic population, untreated and treated. In 1948, the leading mental health authority in the Federal government declared this unequivocal view of that assumption:[20]

> The large number of prevalence and incidence studies of hospitalized psychotics are inadequate for our purposes on many counts. First of all, they deal with only part of our problem, the seriously ill. Secondly, they deal only with that portion of the seriously ill which becomes hospitalized. Third, they can deal only with those socio-environmental factors which are included on hospital records. These studies are in no sense carefully designed experiments to explore relationships or test hypotheses by means of original data. The researchers have no control over the case-finding process, over the record keeping, or even the diagnosis. Rather, they are dependent upon (1) the public's uneven willingness to give up its mentally ill members and to support them in institutions, (2) the hospitals' unstandardized record-keeping activities, and (3) the hospital staffs' varied training and skill in classifying disorders. Finally, the studies have not always been made with much perception of sound methodological principles.

Several years later Gruenberg amplified this position: "I would criticize the use of hospital admissions as something to study. I don't think that it [hospital admission] is a good definition of illness. . . . The more we get into it, the more clear it becomes that it doesn't have any substantive meaning." [21]

Despite these pointed criticisms, enumeration studies of patient records have continued to be made for the express purpose of testing hypotheses that are predicated on the universe of mentally ill people rather than on its treated segment alone. To be sure, some of these investigators have attempted to justify their formula of equating the aggregate of treated cases with the population of sick people.

For example, one researcher used hospital admission rates to test (and confirm) this hypothesis: "The emotional security and social stability afforded by married life make for low incidence of mental illness. . . ." Offered in explanation for the use of *hospitalized* mental illness was this reasoning: "Data on the total incidence of mental illness are almost non-existent. The best available measure of incidence is admission rates to mental hospitals. Whether or not the proportion of the mentally ill who are hospitalized differs by marital status from the total [of] mentally ill is purely a matter for speculation. . . . Since there was no alternative, hospital admission rates were employed . . . to test the hypothesis. . . ." [22]

Here, "best available measure" reduces itself to one assumed to be the only one available. Moreover, the suitability of this forced choice for the stated hypothesis is left dangling as a matter of pure speculation.

The New Haven investigation marked a definite step forward in two respects: (1) It covered ambulatory as well as hospital patients, and (2) it framed three of its five major hypotheses in terms appropriate to the use of patient frequencies as the test yardstick. However, two of the five hypotheses referred to the totality of people in "psychiatric difficulties," and then proposed to use mental *patients* as the test population.[23]

The New Haven monograph is exemplary in the numerous reiterations that its unit of observation is the psychiatric patient. Sporadically, however, it slips into the implication that it is studying the universe of mental illness. Of particular interest is its claim that in comparing patients and nonpatients in each social class, "broadly speaking we compare the mentally 'sick' with the mentally 'well.'"[24] Seemingly implied is the two-part proposition: (1) All or most of the sick are patients, and (2) all or most of the nonpatients are well. The proposition thus offered us is strictly speaking not an axiom that can be accepted as if it were self-validating on its face.

Even more striking is the New Haven conclusion: "We are impelled to infer some subtle connection between class status and psychotic illnesses that we cannot explain away by questioning whether the data are for all cases or only for those in treatment."[25]

The inference may perhaps be correct as stated in a form referring to the totality of psychotic cases. However, to suggest that the specific nature of the population from which the inference has been extracted is an irrelevant matter reflects a somewhat free reading of the laws of evidence. Such a reading is apparent in most of the literature of patient enumeration studies. Despite the absence of supporting evidence and ample indications of face invalidity, such studies have often claimed, tacitly or explicitly, that treated cases are a valid measure of what epidemiologists want to know about the mentally ill as a whole. Moreover, their generalizations from the former to the latter have moved from the pages of an extensive literature into the stream of scientific knowledge. Notwithstanding several dissenting voices of considerable authority, this claim, by a process of selective inattention, continues to be widely if not universally accepted.

From the beginning of the Midtown investigation, the writer fully shared the critical views of Felix, Bowers, and Gruenberg quoted above. With the Midtown Treatment Census and Home Survey operations juxtaposed, it was possible to put these views under crude empirical scrutiny.

As a major point of approach to our Treatment Census, we reviewed Midtown's patients in the care of clinics and office therapists. Midtown's *clinic* cases of this type exceeded New Haven's rate by a margin of 2.5:1, a difference illuminated by the fact that Midtown's home borough

had 2.2 as many clinics (per 100,000 population) as did New Haven. In turn, Midtown's *office* patients outnumbered New Haven's by a ratio of 4.0:1. Of relevance to this difference is that compared to New Haven, Manhattan had 4.4 times as many office therapists per 100,000 population.

Also pertinent is that in both communities treatment capacities of clinics and office therapists were far from meeting *manifest* demands for their services. Similarly, the state mental hospital systems serving these two communities were known to be overcrowded by 25 to 30% above their official bed capacities. In the light of such conditions, it was plain that hospital and ambulatory patient rates reflect inter-community differences *not* in over-all frequencies of mental illness but in bottleneck limitations of available professional personnel and their treatment capabilities.

If the Midtown Treatment Census could tell us nothing beyond the population of therapist-attended mental illness, the companion Home Survey could elicit rough approximations of the volume of unmet need for such services. In the Impaired mental health category of the Home Survey sample we had a resident community group that entailed a risk of need for professional help. To this sample group we applied the broad criterion of "patient history"—defined by the minimum of spending one or more sessions with a psychotherapist. Among these Impaired respondents, 26.7% had ever been patients in this particular sense during their lifetime. The remaining 73.3% had never been to a psychotherapist. The latter included 29.1% who appeared ready to accept psychiatric or other professional intervention—offering a rough estimate of unmet effective demand for helping services. Another 44.2% of Impaired respondents were never-patients who seemed to reflect no immediate awareness of professional help as relevant to problems of emotional disability, and thus are unlikely to enter the market for such services, at least of their own accord. In fine, the large problem of unmet need seems to hinge in part on shortages in the supply of treatment capacities to meet effective demand and, in part, on a potential demand that is still dormant.

To generalize from studied psychiatric patients to the unstudied total population of mentally ill, investigators should have evidence that one of two conditions obtain: (1) The untreated ill are relatively few in number and therefore cannot significantly affect the generalizations drawn (the 1880 national census of psychotics[26] and the Midtown Study of 1954 both offer suggestive empirical grounds for rejecting this first possibility); or (2) the untreated ill are indeed numerous, but are nonetheless similar to the patients in demographic and other characteristics. In tacitly accepting this possibility as validated, previous in-

vestigators operated without a visible foundation of evidence. Here also the Midtown Study can throw some suggestive light.

In the Home Survey sample of adults, impairment rates tend to *increase* with age. Among the Impaired, on the other hand, we found that ever-patient rates tend to *decrease* with age.[27] On the scale of socioeconomic status, the Midtown Treatment Census reported that Total Patients rates (hospital, clinic, office facilities) *increase* upward with SES. Nevertheless, the Midtown Home Survey found that impairment frequencies *decrease* upward on the SES ladder. This seeming contradiction is clarified by the finding among the Impaired that ever-patient rates *increase* upward on the SES scale. That is, at the bottom of the SES continuum, relatively many Impaired people yield relatively few patients, whereas at the top of the continuum relatively few impairment cases yield relatively many patients. Essentially the same countertrends of impairment frequencies and patient rates emerged from our analyses of the age, generation-in-U.S., and religious-origin variables.

In Midtown at least, the frequencies with which the named independent demographic factors yield mental morbidity are almost the reverse of the frequencies with which help-needy people in the several demographic groups manage to cross the threshold of a psychiatric setting. In other words, here the treated are a small and (except for sex and marital status composition) a completely unrepresentative segment of the Impaired people. Relative to the logical problem posed above, generalizations from the patients' data to the latter are accordingly fallacious in almost topsy-turvy fashion.

As for the logistic problem raised earlier, Midtown relative to other communities is uniquely favored in the size of its treatment facilities. Nevertheless, the clogged bottlenecks that actually describe these services force the splitting of the help-needy into two different traffics. More likely to appear in the patient traffic are adults who in age are younger (20 to 39), in own SES are of the upper or middle brackets, and in nativity are American-born. More heavily concentrated in the untreated stream are adults who are older (40 to 59), of lower SES, and of foreign birth.

In part, the demographic divergences between the two traffics seem to be a function of self-selection, arising from their differential awareness of, orientation to, and means to secure the services of a therapist. But in some part, and here we stand entirely on the New Haven investigators' observations,[28] these demographic differences may also be a function of professional selection based on assumptions about treatability, prognosis, or sociocultural congeniality. That questionable prejudgments may operate in this selective process is hardly a negligible possibility.

For public policy in planning the expansion of psychotherapeutic

facilities, we suggest that careful assessment of *both* traffics will be indispensable.

THE INDEPENDENT DEMOGRAPHIC FACTORS: FURTHER HYPOTHESES

From this excursion we return to the exposed links between mental health and the independent demographic variables. The latter were chosen for principal exploration because they crosscut the community landscape into group subdivisions which may harbor one or more focal breeding grounds of mental illness.

Among the six factors of this type tested in the Home Survey sample, three embodied groups that under systematically controlled analysis yielded unusual divergences of mental morbidity rate relative to frequency of wellness. To circumscribe such a deviant group is to delineate a sociocultural *habitat* in which there is a probable imbalance of pathogenic and eugenic life conditions, but is not to identify the specific chain of conditions that have such seemingly weighty consequences for the mental health of its inhabitants. To be isolated from its tangled group context, this chain of component factors[29] requires pinpointed research tailored to a formulation of the specific nature of that group, its processes, and its problems. While designing the present Study we lacked the prescience to anticipate which demographic variable or variables would prove to be related to mental health, if any! In short, for purposes of testing hypothesized component factors, such a sharply tailored focus could emerge *a posteriori* from the Home Survey demographic data but could not be built *a priori* into its operational framework. Those component factors selected for coverage in the survey interviews accordingly were not remotely inclusive of their universe of life conditions and were more or less generalized in their sociocultural anchorages, rather than demographically pinpointed. The results of testing for possible ties between these delimited components and mental health provide the substance of the Midtown monograph's second volume.

However, from data in the present book that highlight several demographic variables and their differentially skewed morbidity-wellness distributions, we could advance a number of explanatory hypotheses that may conceivably account, at least in part, for each such intercorrelation. The first of these implicated demographic variables among the Midtown adult sample was SES origin, which refers to an overarching web of life conditions within and around the respondent's childhood family.

In sociological perspective, the normal family unit is seen to operate through fluidly patterned interactions and affective exchanges, overlay-

ing currents of potentially disruptive impulses that are contained within constructive limits by a delicately geared system of checks[30] and compensatory balances. How effectively and consistently the family actually performs its central sex-canalizing and child-training functions within this intricate, impulse-harnessing apparatus depends in part, we suggest, upon its surrounding sociocultural medium, the margins of self-correcting maneuver open to it under potentially unbalancing crises, and the asset-liability resources available in the marital bond, social skills, and personality structures of the parents, e.g., their relative psychosocial maturity.

Addressing the suggested criterion "margins of self-correcting maneuver," we note the likelihood that prolonged economic hardship in the lower-SES-origin family—and specifically that belonging in parental stratum F—left little or no room for defensive counteraction when such crises as parental disability, unemployment, or death came to roost, which in this stratum they did quite frequently. Given this kind of last-straw assault, the overwhelmed, poverty-stricken family tends to fall apart, with its member fragments scattered to the winds among institutions, kin, and foster homes. Under such blows, this "end-of-its-rope" kind of family appears to be brittle and disintegrative, whereas families with the means and skills of self-repair, facing similar life ruptures, would more likely exhibit reintegrative resilience.

No less serious for the *intact* stratum F family, we posit, is the grim day-to-day grind of poverty or near-poverty in thwarting and intensifying the child's elementary creature needs, retarding thereby normal development of his impulse-modulating mechanisms and furthering an immature and inadequate ego structure.[31]

Within a community of families more or less uniformly on this same economic plane, the deprivations felt would be real enough but rendered somewhat less intolerable by being the common lot. However, within a community also characterized by a wide range of wealth and opulence, the magnitude of these deprivations[32] on the one hand is grossly accentuated; on the other it is stripped of the slender supports that attach to the inclusive lifeboat "company of misery." In such a setting of glaring contrasts, the child would tend to develop an unfavorable view of the father's adequacy as a breadwinner and probably join mother and siblings in disparaging and rejecting father's claims to family respect and authority. Thus, the baleful substandard wage a man earns for a full week of labor may often contribute in no small way to his damaged self-regard, his emotional instabilities, his escape tendencies and retaliating aggressions against his rejecting wife and children—all adding their weight to produce the inverted pseudomatriarchal cast repeatedly observed in families at the lower stretches of the social class range. For the father-rejecting child, we need hardly speculate on the developmental

consequences of overdependence on the heavily burdened, husband-rejecting mother figure.

The community is directly implicated in this bleak family picture through the unviable wage scale it sanctions for the least attractive work functions in its economy. The American community is doubly implicated in that it enmeshes such a worker and his entire family in its often verbally guarded but behaviorally unconcealed process of stigmatizing and rejecting them as a lesser breed of human animal. This it does while declaring its general commitment to the democratic canon that intrinsically all men have equal claim of access to the dignity and material necessities of the human estate. This cultural self-contradiction, we could assume, contributes its own measure of damaging insult and conflict to the child's self-image, ego defenses, and motivational energies.

Thus, we postulate that (1) handicaps in personality resources, social skills, and cohesions of parents, (2) the complex of effects directly generated by poverty, and (3) the community's stigmatize-rejection process, mutually reinforcing each other, may go far toward explaining this key Midtown finding: Offspring of low SES-origin families at all adult age levels reflect maximum vulnerability to mental morbidity and minimum fulfillment of wellness.

The Midtown data tell us that although such vulnerabilities are most prevalent in respondents from low SES-origin families, they are nonetheless present on *all* parental-SES levels.[33] Furthermore, the Midtown data suggest that these covert susceptibilities on all socioeconomic strata erupt into overt forms when sparked by precipitating events occurring with mounting frequency along the adult age continuum.

Many of these events involve changes in social role that catch the vulnerable individual without adequate defenses, thereby taxing his morbidity resistance to the breaking point. Such events are distributed across the adult span, but the two most powerful fall, we believe, at investiture with or divestment of the parental role. Those who buckle near the earlier juncture often cannot tolerate having a helpless child on their hands; those who give way around the later point tend to lack tolerance for the maturation of dependent children. Also involved at this stage, we believe, are the first shadows of a community stigmatize-rejection process, as it attaches to those approaching exits from the prime-of-life phase of body development, with foreseeable descent in social value and esteem. In this formulation, then, SES origin pinpoints locations of differential "sowing" of latent pathology, and the age factor highlights clustering points in the "reaping" of overt morbidity.

The third demographic factor found related to mental health was localized in the Midtown generation I group, or more specifically in its contrasting type O (rural, "lower"-SES origin) and type N (urban, "middle"-SES origin) immigrants. In a strict sense, migrants appear to

be a self-selected element and therefore should stand in the reciprocal category of demographic variables along with marital status, own SES (as influenced by status mobility), and own religion (as influenced by affiliation change). In fact, we do place Midtown's American-born in-migrants in this category.

We now regard the generation I group somewhat differently, out of several complex considerations. With reference to the reciprocal variables just mentioned, we were of the opinion that the mental health profiles presented by their Midtown subsamples were composites, so to speak, their principal lines determined by the selective processes of personalities volunteering in effect for placement in these sample subgroups. Implied is the hypothesis that mental health changes specifically traceable to membership in such voluntary groups are of secondary magnitude compared to the mental health differences that in the first instance determined varying memberships. Stated differently, we would expect longitudinal research exploration of these factors to show a fair degree of congruence in mental health trends between the premembership and postmembership periods.

In the case of immigrants, on the other hand, we predict longitudinal research would show for the O-type subgroup a very substantial incongruence between its premigration and postmigration mental health. However the processes of self-selection led people to consider migration, among both type O and N populations (in their homelands), the United States visa-screening apparatus almost certainly worked to "homogenize" those who applied and subsequently were accepted—in a direction that tended to exclude all the sick as well as the postmorbid and many vulnerables in the premorbid stage. If so, to a degree this leveled down mental health differences that would probably have characterized groups O and N had their migration been "free" and wholly self-determined.

On this ground, we can plausibly assume that the large mental health contrast observed between Midtown's type O and N immigrant subgroups is less a function of premigration divergence in their vulnerabilities to illness and more a consequence of differences in their postmigration predicaments. Given the essentially exogenous nature of these predicaments, as created in effect by immersion in the metropolitan American environment, we can regard the immigrant subgroups as approximating a quasi-independent factor; i.e., they essentially conform less closely to the reciprocal than to the independent type of demographic variable.

Specifically, types O and N clarify role discontinuity as a concept referring to a large genus of stress-inducing events. In its essentials, the concept denotes the predicament of acquiring, changing, or vacating an important role, involving a transition for which there are inadequate personality resources and insufficient preparation. Its significance, we

posit, is that such role shifts during the adult life history are sharp thrust points for the breakdown of latent pathology into overt morbidity.

Immigration is preeminently a situation of role discontinuity in that it forces upon the individual gross changes across most of his interpersonal roles. However, the extent of change hinges upon the degree of contrast between the immigrant's native and adopted environments. For Midtown's "middle-class" immigrants from Europe's continental urban centers, the contrast may have been primarily on the level of language and other internation differences of culture that can be bridged in due time; and to judge from our sample type N immigrants, the initial strain of adapting to discontinuity of this degree is without lasting, discernible pathogenic significance—at least upon examination several decades after arrival in this country.

However, when to these dimensions of "foreignness" are added those of the minimally schooled landsman, conditioned to the roles and tight little world of the European village but now lost in the cliff-dweller recesses of the huge American metropolis, then the contrast and the resulting discontinuity approach maximum. And to judge from the mental health of our sample type-O immigrants, role discontinuity on this gross scale joined to poverty that is often the lot of such immigrants, and the stigmatize-rejection process casting them as especially benighted aliens, together provide a pathogenic "wallop" for the more susceptible people in this far-traveled group.

Postulated as threading through the three demographic variables that proved positive in tests of relationship to mental morbidity were varying combinations of three potentially malignant, socially linked phenomena, namely, (1) the poverty complex, (2) the role-discontinuity predicament, and (3) the stigmatize-rejection mechanism. Nowhere in this book have we viewed such noxious intrusions into the individual's life stream as precluding the simultaneous operation of pathogenic somatic factors,[34] either as primary or secondary contributions to the emergence of mental disorder. No less emphatically, these intrusions are far from encompassing the entire universe of exogenous sociocultural factors that can be implicated as potentially pathogenic for personality development. Nevertheless, they represent discernible orders of social experience that together may account for a substantial portion of dysfunctional environmental inputs into family units, where they can strain or dislocate the intricate checks-and-balances apparatus of the family's impulse-disciplining system—strain which is likely sooner or later to yield mental disturbance as a system output. Underlying this hypothesis is the writer's basic assumption that mental morbidity is in part immediate manifestation of an impaired ego structure, damaged by a malfunctioning intrafamily impulse-control circuit that, in turn, has

been rendered defective, at least in part, by disabling intrusions from or defaults in the sociocultural medium of the cradling community.

THREE SOCIOCULTURAL DYSFUNCTIONS: HISTORICAL TRENDS

Also implied in the above data-stimulated hypotheses is the view that if the three intrusive phenomena here held pathogenic for family functioning are socially generated, then they are potentially open to social processes of correction. Can this view be documented?

Historical perspective recalls evidence about the secular course of poverty trends. In the five decades between 1900 and 1950, the average American factory worker's change of lot may be grasped in the facts that his real income (purchasing power) doubled, while his work week contracted from sixty (or even more) hours to forty. Taking all of the nation's household units as distributed by income level, the U.S. Census Bureau reports that the proportion with annual incomes under $3,000 (standardized in terms of 1950 dollars) fell from 67% in that "golden year" of 1929 to 54% in 1941, to 40% in 1950, and to 30% in 1957. Between 1950 and 1957, New York State's corresponding income group dropped from 32% of all households to 15%.

By the calculations of the New York City Welfare Department, the annual income required in 1959 to sustain a City family of four at a minimal subsistence level for health and safety was $3,900.[35] When interviewed in 1954, some 38% of the Midtown sample reported family income (from all sources) below the $3,900 figure, with about half of these reporting $3,000 or less. Pertinent here is that the City's press has regularly inveighed, in the words of the *New York Times*, against "the comfortable idea, so widely held, that there is no low-wage problem in this high-wage town."

Since 1935 Federal policy has supported skilled and semiskilled blue-collar labor in their sustained, organized effort to lift earnings from the bare subsistence level. A. H. Raskin, labor editor of the *New York Times*, has referred to this advance as bringing "a new sense of economic emancipation and dignity to millions of workers." Moreover, for the first time since the twenties, white-collar workers in the decade following 1947 outstripped industrial labor in relative income gains, with the advances most pronounced, according to the National Bureau of Economic Research, in the topmost brackets.

By contrast, unskilled and semiskilled labor important in the services functions and in "incubating," marginal, or seasonal industries, on certain sectors has lagged behind the general advance. Only part of this group has had the presumed protection of minimum wage laws on state and Federal statute books. Even for the protected segment, however, prac-

tical significance of the $1–1.25 per hour minimum enacted by Congress in 1961 must be judged in light of the $3,900 minimum "for health and decency" defined by the New York City Welfare Department as a standard for a local family with two children. Thus, as a family-supporting income norm the legislated wage floor for many is hardly more than a sympathetic gesture. Nonetheless, the gesture is intrinsically important in signifying that the "ragged lower edges" of the wage structure in principle are matters of public interest and are subject to legislative control. When this declared responsibility of public policy is more realistically and completely implemented, we shall move farther toward ending what Victor Hugo one hundred years ago called one of "the problems of the age—the degradation of man by poverty."

The specific preventive goal to be reached has been declared in the thesis advanced by a great social historian:[36]

> The problem of preventing poverty is not primarily to assist individuals who are exceptionally unfortunate. It is to make the normal conditions under which masses of men work and live such that they may lead a healthy, independent and self-respecting life when they are *not* exceptionally unfortunate; so that when they are exceptionally unfortunate, misfortune may not descend upon them with the crushing weight with which it falls today upon large sections of the working classes. . . .

In the stigmatize-rejection mechanism here considered pathogenic for its objects, we confront the entire evaluative apparatus of the society's status-allocating system. Under a complex division of economic labor, such a system is probably inevitable.[37] Not inevitable in such a system,[38] however, is that families should be denied the elementary respect of their economic "betters" because the breadwinner performs a "hewer-of-wood" work role, or has migrated from abroad, or is more heavily endowed in skin pigment, or has reached retirement age. It is our impression that the prestige-evaluation system of Britain, although anchored to royalty at one extreme, is more advanced than America's on this crucial issue of according respect to, and expecting self-respect in, its less advantaged groups.

Involved here obviously is the contrademocratic, stereotypic tendency to take the current social acceptability of a position or group as a criterion for ascribing a corresponding value to its members' character and worth as individuals.[39] Of course, the most extreme manifestations of this tendency continue to be directed toward Negroes and other nonwhites. The century-long struggle to eliminate this interracial pecking-order phenomenon has slowly but inexorably moved forward and is patently gathering momentum. However, the larger national pattern, to which denial of Negro equality and respect stands as part, must be kept in focus as an integral moral problem that cuts across racial lines. For we hold the hypothesis that wherever this degrading, antidemocratic

pattern operates, there it also penetrates the victimized with ultimately damaging psychological effects.[40] If so, further extensions of democratic practices in the community, to accord with both the letter and the spirit of the nation's founding documents, would be validated on mental health criteria as surely as they are imperatives on ethical grounds.

The jolting impact of role discontinuity on vulnerable personalities, inferred from our age-trend data and since observed by the writer in psychiatric patients of a New York municipal hospital, may be viewed as in part the result of cultural failure to provide a bridge of training for the individual, preparatory to assuming, changing, or departing an important social role. We detect two practical implications in this suggestion. First, role transitions occur in especially rapid sequence during adolescence and early adulthood, e.g., puberty, entering high school, dating, entering college, launching career, and courtship. At these transfer points in particular, signs of potential psychiatric morbidity may show themselves in relatively clear but transient forms. If so, for preventive measures to be applied at such junctures, parents, teachers, physicians, and clergymen might be alerted to pay special attention to individuals who appear to be having major trouble in getting over a generally acknowledged minor psychological hurdle.

Second, the educational apparatus might be deliberately geared to anticipate that for many people a role change tends to place new demands upon their adaptive resources. Thus, for those approaching such change, group discussion and individual counseling on the nature of the new role setting and its psychological demands might be explored as a prophylactic help in smoothing the transition.

On its own self-correcting powers, the American community has moved, albeit at a seemingly glacial tempo, toward the still distant goals of eliminating the economic roots of poverty and of according first-class citizen stature to those previously denied it. In a related development to correct a sociocultural default, many universities for some years have been offering course programs in "family life" that bear in particular on marital and parental role requirements. No less noteworthy, postacademic adult instruction of this kind has emerged as a national movement under the banner of "education for parenthood." [41]

The reader will have recognized that we have ranged far around the anchorages of our data. To account for the Home Survey's major demographic findings, we have pointed a hypothesizing finger at three plausible broad-gauge sociocultural processes. However, these postulates were not reached by any leap of imagination. They rest instead on wide but scattered observations, both sociological and psychiatric in nature, gathered by the writer before and since the Midtown investigation and left unsystematized until forced by these synthesizing pages.

We have suggested that America's capacity to generate its own social pressures for correction of its systemic dysfunctions and defaults is documented in the evidence that it has made discernible progress (1) in reducing the prevalence of poverty-burdened families, (2) in enlarging the range of equalitarian behavior, and (3) in addressing the need for education in family living.

These trends in turn have moved on a larger tide of social change, running for more than a century with such sweeping force that it has justly been called a cultural revolution. Powered by accelerating scientific and technological advances, among its profound achievements the movement has enlarged access to high school and college education,[42] opened the social class system to greater status mobility, expanded the time and means available for recreative leisure, improved nutrition, lifted the specter of infectious[43] and deficiency diseases, raised the general level of physical health, increased life expectancy at birth from about 43 to 68 years,[44] and to a large degree emancipated women from their dependent, constricting domestic role and original legal status as chattels.

With these massive humane gains have come a number of secondary side effects, including psychological strains inherent in adapting to rapid change, tensions generated by the heightened insecurity and competitiveness of a more fluid status system, erosions in the doctrinal and moral areas of the religious sphere, and loosening in the cathected qualities and supportiveness of interpersonal relations. To this incomplete list might be added extension of the concept of machine and product obsolescence toward economic and social devaluation of the aged.

THE CULTURAL REVOLUTION: MENTAL HEALTH CONSEQUENCES?

This cascade of changes, primary and secondary, poured into the innermost recesses of family life, with such effect that the average American of a century ago would likely find his descendants' families of today difficult to recognize as social kindred. If we were required to venture a probability estimate of the mental health consequences that have followed in the wake of the century-long cultural revolution, we would offer this as our most general extrapolation: Weighing the primary gains and secondary side effects outlined above suggests a likely net effect of large-scale *improvement* in the over-all mental health composition of the American population.

The writer can carry this retrospective projection in several more specifying directions, guided by suggestive hints in the data chapters above and framed in the three major mental health categories of the

Study psychiatrists. First, we believe that the greatest mental health improvements have occurred at the points of largest relative contributions to normal family functioning, namely, in the upper and middle blue-collar occupational categories.[45] We doubt that the improvement in these groups appeared in any appreciable enlargement of wellness as such, but rather in a considerable reduction of mental morbidity at the cost of a corresponding increase in the subclinical conditions.

We can postulate that for the white-collar classes the primary advances of the cultural revolution on the whole have been less significant for mental health than its secondary side effects. Specifically, we believe that the latter tended to enlarge the frequency of the subclinical conditions (toward equivalence with their prevalence in the higher blue-collar classes), at a cost of contraction in the number of Wells, with perhaps the morbidity rate altered little.

Viewed over-all in terms of the bar-chart format of Figure 5, we posit that had the Midtown Home Survey been made fifty years earlier it would likely have shown zones C and D proportionately much broader in base and higher in Impaired-Well magnitudes than in 1954, with zones A and B far narrower on the horizontal axis and somewhat lower in Sick-Well ratios than currently. In short, we consider as probable that the own-SES differences in mental health composition were *then* far more sharply contrasting than in the situation revealed in Figure 5. Telescopically phrased, narrowing of socioeconomic differences has been accompanied by narrowing of mental health differences.[46]

Another set of more recent cross currents seemingly discernible are improvements in the mental health composition of three groups: (1) of immigrants, relative to their predecessors, (2) of women, toward equivalence with men, and (3) of young adults, relative to their age and social class peers two or more generations ago. Among the aged, on the other hand, the presumed eugenic effects of increases in longevity, standard of living, and economic security may have been partially offset by the potentially pathogenic social changes now rocking this rapidly growing group.

These probability extractions of mental health shifts, drawn from known cultural changes and from clues intimated by the Midtown demographic data, are carefully considered judgments. Nonetheless, others reading from the same known values and clues will doubtless reach and justify different interpretations.

The issues posed have arisen from the hypotheses formulated to help explain our major demographic findings. These issues are relevant for another reason: Sociologists, in contrast to economists, have been predominantly preoccupied with the side effects, far more than with the main sociocultural advances, of the past century. Accordingly they have often assumed a population trend of progressive mental health deterioration through this period. Goldhammer and Marshall,[47] apply-

ing Massachusetts' incidence of psychotic hospitalizations as a criterion, reported that in the span of a century (1840 to 1940), there had been no increase in these hospital rates within the population below the age of 50. Although these authors challenged the popular assumption that the over-all frequency of such mental disorder had increased, Jahoda[48] has pointed out that they did not contemplate the hypothetical possibility that its frequency trend might have moved toward contraction. Thus, it has been one purpose of the present discussion to reopen consideration of this generally overlooked possibility[49] and stimulate search for untapped sources of documentary evidence that may permit its assessment.

IN PROSPECT

In looking forward, we would first detour briefly to sketch several lines of further research that seem to extend directly from the present investigation.

1. Improved replication of the Home Interview Survey in American communities scattered along the rural-metropolis continuum is indicated. It is deemed necessary for systematic comparison of such localities within a framework comprehending and articulating their sociological characteristics, demographic structure, and mental health composition.

2. Necessary to supplement such cross-section surveys are longitudinal studies of children, adolescents, or young adults. These might focus on differences in social paths followed, e.g., upward versus downward socioeconomic mobility, marriage versus bachelorhood, or migration versus locale fixity, to parcel out (*a*) the selective personality determinants of such differences from (*b*) the mental health changes that subsequently emerge from experiences indigenous to each path. By resolution of the difficulties and ambiguities encountered by cross-section investigations in dealing with certain important demographic variables, such cohort studies promise to reach new ground, as have their recent research predecessors in the epidemiology of somatic disease.[50]

3. Large-sample surveys provide a scanning overview of the community landscape for detection of intergroup differences in mental health. However, their extensive coverage is bought at a price of loss in intensity of individual examination. The Midtown data have revealed that three independent demographic variables are significantly related to mental health. The nature of the findings suggested a number of hypotheses that might partially account for the effects of these variables. It is now appropriate to explore these hypotheses by intensive examination of small samples of accessible clinic patients sorted according to the three main demographic factors here implicated, namely, SES origin, age, and the immigrant O-N typology. The goals of such clinic studies would be (*a*) to assay the explanatory power of the

hypothesized poverty complex, role discontinuity, and stigmatize-rejection processes and (*b*) to revise, expand, and supplement these hypotheses in terms of more inclusive chains of life conditions. Hopefully these will enhance our ability to account for the total mental health impact of each demographic group on its progeny.

4. Given such refinements, these hypotheses could next be more definitively tested in community sample studies of the cross-section type, but now more intensively focused on narrowly circumscribed demographic groups.[51] Furthermore, "crucial-test" groups not present in Midtown might also be encompassed at this stage. To this end it should be recalled that in the Midtown sample nonwhites were represented in numbers too few for statistical analysis of any kind. To be sure, the sample's 27 Puerto Ricans were more numerous and revealed an unfavorable mental health composition more extreme than encountered in any other sample group. Unfortunately, even this number is too small to be turned to further statistical analysis with the necessary controls.

It is clear of course that if the socially implicated poverty complex, role discontinuity, and stigmatize-rejection processes are indeed pathogenic, then Negroes and Puerto Ricans, deeply enmeshed as they are in all three processes, must emerge with Impaired-Well imbalances more skewed than any discovered in the Midtown sample's white subgroups. According to our hypotheses, moreover, we can predict that these imbalances would be more extreme among lower-class than middle-class Negroes, and more extreme for colored than for white Puerto Ricans in both the O and N categories of immigrants. Tests of these predictions would provide decisive evidence as to the tenability of the hypotheses extracted from the Midtown demographic data.

5. The most refined research necessary to a rounded scientific program, in the author's view, is directed on the one hand to exploring the structure and dynamics of the major types of personalities[52] and on the other to charting the structure and mechanisms of the family as a delicately circuited (and easily short-circuited) impulse-affect-energy system. Despite great diversity in the personality combinations appearing in husband-wife couples, it is the observation of this writer that (*a*) the architectonic types of family systems created are limited in number, and (*b*) the family-of-origin types associated with the major emergent forms of pathognomonic personality are even more limited in number. This line of thought will be elaborated elsewhere. However, in the present context it can be suggested that systematic conceptualization of a concise morphology of family types, hardly begun, is one of the urgent tasks before social science and psychiatry.

Clinical psychiatry of course takes into account the patient's family of origin within the more or less descriptive, discursive framework of the case history. However, if one main line of etiological search must

explore the impacts of exogenous sociocultural forces and intrafamily processes on personality development, then necessary to this end is a workable taxonomy of family systems, representing the mediating or intervening variable in the nexus. Acceleration of this search with the family as the basic unit of observation may rest on such a conceptual advance.

We would turn now from the family as unit of observation to the family as prime lever of changes that might flow in feedback from scientific observation. In a sense, the support extended this investigation on all levels of Midtown leadership is evidence of readiness for such a development. Further evidence are the sample adults in 1,660 Midtown households, who gave generously of their time and themselves out of the sole expectation that such scientific inquiries ultimately "make a difference" for the general good.

On the national scene, there is growing awareness, at least among the college-trained, that parents and community, whether or not they so will it, hold in their hands great powers over the mental health fate of their children. With such awareness, they are putting to themselves these hard questions about their own child-directed behavior: What are we doing that is incorrect? What are we not doing that may be correct? [53]

Resonant in these questions are tones of objective self-appraisal and of openness to change—notes that are probably new in the long history of the human family. Discernible here, we believe, is a kernel of the professional helping role that operates in the knowledgeable light of what Bettleheim has succinctly and felicitously called the "informed heart."

In point of fact, this general criterion has been taking root in widening spheres of communal affairs. It was manifest in Louis Brandeis's long campaign to have the courts give to the human consequences of a raw, insensate industrial economy a weight transcending that claimed by the armored precedents of legal tradition.[54] The criterion was made explicit by the United States Supreme Court in its 1954 decision banning racial segregation in public schools.

Recently the criterion has penetrated into the very fortress of religious institutions, through their theologians, divinity school faculties, younger clergymen, and rapidly growing corps of trained pastoral counselors and mental hospital chaplains. Undergoing drastic revisions among Protestant clerical leaders, for example, are the millennial key Christian concepts of sin and of God. Consider these comments of an eminent Protestant theologian:[55]

> It is an astonishing fact that Protestant theology had to rediscover its own tradition about what man is and about what healing powers are through the impact of [Freud's] psychology of the unconscious. . . . If asked whether the experiences of pastoral counseling and its theoretical support, psychotherapy,

had any influence on the idea of God, I would say, profoundly so. . . . One can say that psychotherapy has replaced the emphasis on the demanding yet remote God by an emphasis on His self-giving nearness. It is the modification of the image of the threatening father—which was so important in Freud's attack on religion—by elements of the image of the embracing and supporting mother. . . . Acceptance by God of him who is not able to accept himself has become the central Christian message.

Here is a veritable theological transformation acquiring momentum on a scale probably unprecedented in the centuries since the Reformation. As fathers of Protestant thought, Luther and Calvin at important points have given way to the dynamic insights of Freud. Parallel developments are under way in the sanctuaries of both Judaism and Catholicism.

These are all facets of a larger development gathering momentum that Sanford [56] sees foreshadowing a "new era of scientific humanism." It is one offering the hope that social change, heretofore in part a matter of rudderless drift on the sweeps of powerful cross currents, will have a compass marking directions for the community to steer its own course both by the criterion of its people's psychological well-being and by its transcending moral imperatives.

This perspective has been given new depth by Gardner Murphy's recent monumental work,[57] which breaks decisively with traditional conceptions of the static limits of human nature. Murphy's book opens vistas to untapped creative powers imminent in the human frame and in the social sphere, as their interdependent potentialities are liberated by scientific advances in the service of democratic values.

Toward this distant horizon, a nearer goal is the control and prevention of the emotional blights that stunt and cripple their victims in large numbers. If the Midtown Study in any way illuminates the proposition that such blights may germinate at points of encysted sociocultural dysfunctions, then it will have served the vision of Rennie and his colleagues that called it into being and brought it to the fruition of this monograph.

In brief, whatever the ultimate durability of its findings, the Study might also be judged by one of its underlying purposes: To highlight the large questions the social sciences can now bring to bear on the mental health problems that continue to haunt men in our time everywhere.

FOOTNOTES

[1] Reference made here is to the Home Interview Survey. The far smaller Treatment Census operation had begun its own data culling about six months earlier.

[2] Also, at that time, Thomas Langner and the author of the present chapter began planning and executing the analysis design for Vol. II of this monograph series—a task even more complicated than was the case for the current volume.

[3] We would here underscore the following observations of Escalona and Heider: "Very rarely does the reader learn particulars concerning the investigator's struggle in making sense of his own data. . . . To judge only by a completed research publica-

tion, it would seem as though the researcher's significant activity ended with the computation and the interpretation of results, and therefore as though the 'write-up phase' were nothing but the implementation of decisions which had been made at an earlier time. . . . We, however, are surely not the only investigators who found, especially in exploratory research, that the preparation of a manuscript for publication was an active phase of research itself, and that it entailed significant choices among alternatives. We believe that writing of research reports may profitably be considered as a part of research methodology." S. Escalona and G. M. Heider, *Prediction and Outcome*, 1959, pp. ix-x.

[4] Study reports and papers prepared in 1955–1956, acknowledged as "preliminary in nature," actually proved to be conceptually primitive in our perspective of 1959–1960.

[5] Joint Committee on Mental Health and Illness.

[6] Session of Mar. 11, 1955. Published in the *Am. Psychologist*, vol. 10, no. 5, pp. 221–224, May, 1955.

[7] It is relevant here to observe that this development has not been altogether a smooth one, as Marie Jahoda has indicated: "In the long history of man's concern with mental disease the efforts of social scientists are a very recent innovation. As one might expect in this domain which has traditionally been that of the medical profession and its allied sciences, the newcomer has not everywhere been received with open arms. Even in the United States of America, where the prestige of the social sciences is perhaps greater than anywhere else in the world, the idea that they could contribute to the understanding of this problem is still regarded with suspicion in some quarters." "Environment and Mental Health," *Intern. Social Sci.* J., vol. 11, no. 1, p. 14, 1959.

[8] J. A. Clausen, "The Sociology of Mental Illness," in R. K. Merton et al. (eds.), *Sociology Today*, 1959, pp. 497–498.

[9] "Medicine has three general methods by which to develop knowledge of disease. No single one suffices to the exclusion of the others; each has its individual usefulness, and the fullest measure of progress is to be expected when all are brought into action. The three methods are the clinical study of the individual patient, laboratory experiment, and the epidemiological approach through field and statistical study of disease as a mass phenomenon of groups of people. . . . Epidemiological analysis is not to be construed as a substitute for either of the other methods of study, but as an addition." J. E. Gordon, E. O'Rourke, F. L. W. Richardson, Jr., and E. Lindemann, "The Biological and Social Sciences in an Epidemiology of Mental Disorder," *Am. J. Med. Sci.*, vol. 23, p. 316, March, 1952.

[10] P. W. Bridgman, *The Way Things Are*, 1959.

[11] On this issue, it sometimes seemed that we would be "damned if we did and damned if we didn't." That is, on the one hand the Study would be severely reproved, justifiably, in our view, if the Midtown psychiatrists had principally applied the standard diagnostic nomenclature in classifying the mental health of our sample respondents—under the given limitations in information and conditions of data evaluation. On the other hand, for largely relying on the symptom-formation scheme of mental health gradients devised by the Midtown psychiatrists, the investigation would probably be censured for neglecting to identify mental illness with the nosological specificity seemingly attached to the standard diagnostic nomenclature.

The latter is based, of course, on the Kraepelin system of classification which at time of development "tended to clarify the definitions of the functional syndromes, [but] at present lacks sufficient *reliability* and *validity* for satisfactory coordination of research. Diagnostic criteria vary markedly from hospital to hospital and from one psychiatrist to another. . . . Myerson points out that even when psychiatrists agree as to what constitutes a specific mental disorder they may still make inconsistent diagnoses because of the difficulties in correctly recognizing criteria symptoms when they occur in individual cases. The consequent unreliability of diagnoses limits to an unknown extent the comparability of patient groups, particularly those treated by different investigators." D. I. Malamud, "Objective Measurement of Clinical Status in Psychopathological Research," *Psychological Bull.*, vol. 43, no. 3, pp. 240–258, 1946.

[12] C. H. Lawshe and B. F. Nagle, "A Note on the Combination of Ratings on the

Basis of Reliability," *Psychological Bull.*, vol. 49, no. 3, pp. 270–273, May, 1952.

[13] "To a greater degree than in the longer established sciences, the major virtue which a social scientist must possess to carry on research is the nerve to tolerate imperfection. Research on the social correlates of mental disease demonstrates this virtue to the limit, perhaps occasionally beyond it." Jahoda, *op. cit.*, p. 17.

[14] Of course, this judgment is contingent upon the degree of precision expected. As crude illustration, assume that an observer is assigned to estimate the statures of Smith and Jones by visual inspection. If expected are estimates in terms of absolute inches, the observer may be inaccurate in one or both cases. However, if expected is a comparison indicating only which man is taller, then it is far less likely that the observer's report will misrepresent the situation. In a sense the Midtown Study has been predominantly concerned with the direction or trend of such gross *comparative* differences and relatively unconcerned about absolute measures of magnitudes. The latter were neither achievable nor necessary to our purposes.

[15] That all these considerations also apply in the epidemiological study of somatic diseases has been indicated by E. Gruenberg, "Problems of Data Collection and Nomenclature," in C. H. Branch (ed.), *The Epidemiology of Mental Health*, 1955, p. 67.

Even under these seemingly ideal circumstances for intercommunity comparisons, differences in over-all morbidity rates may be artifacts in whole or in part of unobserved variations in demographic composition. In the end, therefore, such intercommunity variations can be brought under control only by analyzing demographically matched segments of the populations—if this has been made possible by a common research design.

[16] M. Lerner, *America as a Civilization*, 1957, pp. 94–103.

[17] This assumes, of course, that potential biases bearing on different groups have been kept out of the research operations by appropriate control measures.

[18] On this assumption, Chap. 16 offered speculative interpretations of processes in the Jewish family structure that may account for the group's relatively infrequent manifestation of impairment in its more extreme forms. These need not be reviewed here.

[19] A. M. Rose and H. R. Stub, "Summary of Studies on the Incidence of Mental Disorders," in A. M. Rose (ed.), *Mental Health and Mental Disorder*, 1955, pp. 87–116.

[20] R. H. Felix and R. V. Bowers, "Mental Hygiene and Socio-environmental Factors," *Milbank Mem. Fund Quart.*, vol. 26, no. 2, pp. 127–128, April, 1948.

[21] E. M. Gruenberg, "Problems of Data Collection and Nomenclature," in Branch, *op. cit.*, p. 67.

[22] L. M. Adler, "The Relationship of Marital Status to Incidence of and Recovery from Mental Illness," *Social Forces*, vol. 32, no. 2, p. 185, December, 1953. See also R. M. Frumkin, "Marital Status as a Categoric Risk in Major Mental Disorders," *Ohio J. Sci.*, vol. 54, no. 4, p. 274, July, 1954.

[23] A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness*, 1958, p. 11. In the present volume, we take critical exception to technical epidemiological points in four chapters (1,2,7,8) of the New Haven monograph. It is necessary to emphasize that these exceptions in no way detract from our view of the remainder of the latter book as a definitive turning-point work on the unwitting intrusion of social class elements in the operating methods of psychiatric facilities.

[24] *Ibid.*, p. 197.

[25] *Ibid.*, p. 244.

[26] Referring to the national census of mental patients made in 1880, Malzberg reports that "there were 40,942 patients with mental disease in hospitals. In addition, through the cooperation of physicians, a total of 51,017 patients were found outside of hospitals." B. Malzberg, "Important Data about Mental Illness," in S. Arieti (ed.), *American Handbook of Psychiatry*, 1959, vol. I, p. 161.

[27] In Chapter 17 Michael has advanced the possibility that older Impaired people more often than their younger counterparts secure help for their mental health prob-

lems from general practitioners. There is relevant evidence available to assess this possibility. The question of adequacy of somatic therapies aside, it is a fact that in the American white adult population generally, the average number of physician visits per person per year varies little with age below age 60. Specifically, these reported averages are: age 25–34, 5.2; age 35–44, 4.9; age 45–54, 5.1; age 55–64, 5.9. (United States National Health Survey, *Health Statistics: Volume of Physician Visits*, ser. B, no. 19, 1960, p. 18.)

This trend assumes added significance in light of the further national fact that the proportion of adults with one or more chronic medical conditions *does* increase with age as follows: age 15–29, 34.9%; age 30–44, 49.2%; age 45–54, 56.9%; age 55–64, 65.4%. (United States National Health Survey, *Health Statistics: Limitation of Activity and Mobility Due to Chronic Conditions*, ser. B, no. 11, 1959, p. 21.) If an age trend of mounting frequency of chronic somatic conditions is accompanied by little rise in the frequency of "doctoring," the implication is that with advancing age (in the indicated range) both primarily somatic and primarily psychological conditions tend increasingly to go unattended.

[28] Hollingshead and Redlich, *op. cit.*

[29] See Chap. 2, p. 20, for a definition of the component factors.

[30] The most fundamental of these checks is of course the universal incest taboo. Cf. T. Parsons and R. F. Bales, *Family, Socialization and Interaction Process*, 1955.

[31] A French playwright identifies the malaise usually accompanying poverty as rooted in "the feeling that . . . without money, one is someone who, in a sense, does not quite have the right to live; someone who, in a sense, does not exist; someone who fluctuates between being and nothingness." Felicien Marceau, *The New York Times*, Feb. 28, 1960.

[32] R. K. Merton and A. S. Kitt, "Contributions to the Theory of Reference Group Behavior," in R. K. Merton and P. F. Lazarsfeld (eds.), *Continuities in Social Research*, 1950, pp. 42–59.

[33] It is the writer's view that the pseudomatriarchal patterning of the poverty-level family is in part economically determined. It is his impression that such a family pattern tends to emerge less often on higher-SES strata but then, of course, without the provocations of poverty. Clinical observations suggest that wherever and however generated, this family type with its reversals in the parental roles and figures, often complicated by cross-sex parent-child aberrancies in cathexis, is one of the most pervasive etiological root sources of psychopathology in offspring.

[34] See Chap. 2, p. 16, for an extended statement of this explicit position.

[35] The Community Council of Greater New York in 1958 estimated about $4,700 as necessary for such a family "to maintain current standards of adequate consumption at low cost."

[36] R. H. Tawney, *Poverty as an Industrial Problem*, 1913, p. 11. See also J. K. Galbraith, *The Affluent Society*, 1958, pp. 330–332.

[37] Despite the insistence of Marxian doctrine, Soviet Russia has not been able to stand as a demonstration to the contrary.

[38] R. D. Schwartz, "Functional Alternatives to Inequality," *Am. Sociological Rev.*, vol. 20, no. 4, pp. 424–430, 1955.

[39] For an eye-opening account of the history of the process, see R. H. Bremner, *From the Depths: The Discovery of Poverty in the United States*, 1956.

[40] "The damaging effects of [inferior social status] are reflected in unrealistic inferiority feelings, a sense of humiliation and constriction of potentialities for self-development. This often results in a pattern of self-hatred and rejection of one's own group, sometimes expressed by anti-social action toward one's own group or the dominant group. These attitudes seriously affect the levels of aspiration, the capacity to learn, and the capacity to relate in interpersonal situations." *Psychiatric Aspects of School Desegregation*, report no. 37, Group for the Advancement of Psychiatry, Committee on Social Issues, May, 1957, p. 10.

[41] For a description and evaluation of this movement and its program, see O. G. Brim, *Education for Child Rearing*, 1959; and N. N. Foote and L. S. Cottrell, Jr., *Identity and Interpersonal Competence*, 1955.

[42] Between 1900 and 1953 the proportion of 14- to 17-year-olds in American public and nonpublic schools increased from 11.4 to 80.4%. During the same period the proportion of 18- to 21-year-olds who were resident students of American colleges increased from 4.0 to 25.7%. U.S. Office of Education, *Biennial Survey of Education in the United States*, 1957, pp. 26 and 51.

[43] The annual death rate from communicable diseases in the United States fell from 175 per 100,000 population in 1900 to 5.6 per 100,000 in 1953.

[44] This increase occurred between 1890 and 1957.

[45] Indirect evidence supporting this belief appeared in the occupational composition within zone B of the Midtown sample's own-SES classification (Chap. 12, Figure 5).

[46] Lest a superficial theory of economic causation be read into this postulated concatenation, our view can be expressed in an elaboration of an ancient Jewish proverb: It is not that a full purse is necessarily good [for mental health] as that an empty one is almost certainly bad.

With specific reference to public health a biostatistician has concluded: "Fundamentally, health progress depends upon economic progress." M. Spiegelman, "Recent Trends and Determinants of Mortality in Highly Developed Countries," in *Trends and Differentials in Mortality*, 1956, p. 59.

[47] H. Goldhammer and A. Marshall, *Psychosis and Civilization*, 1949.

[48] To our knowledge, Jahoda is the only social scientist to have called attention to this oversight in what stands as a highly provocative work. See Jahoda, *op. cit.*, pp. 14–23.

[49] The general historical trend in mental health extrapolated here is one that has also been hypothesized by Jahoda, *ibid.* It was implicit in Margaret Mead, "One Vote for This Age of Anxiety," *The New York Times Magazine*, May 20, 1956, pp. 13 and 56–58. It finds explicit documentation in a mistitled but insightful autobiographical work by C. B. Davis, *The Age of Indiscretion*, 1950.

[50] Outstanding among these is the twenty-year prospective study of cardiovascular disorders in a Framingham, Mass., sample of men. See T. R. Dawber, F. E. Moore, Jr., and G. V. Mann, "Coronary Heart Disease in the Framingham Study," *Am. J. Public Health*, vol. 47, no. 4, p. 4, April, 1957.

[51] We might note, parenthetically, that the Midtown Study was in part inspired by clinical experience. In turn, the hypotheses stimulated by data from its community population must now be returned to the clinic for preliminary assessment and amplification. So amplified, the hypotheses would next be carried back into the community for definitive testing in demographically tailored samples. Exemplified is the shuttling feedback progression from clinic to community to clinic and back to community, as a research strategy intended to refine and certify the raw inferences extracted in a sequence of steps. In the epidemiological research attack on cancer of the lung now in progress will be found a full application of this comprehensive strategy.

[52] This has been given renewed advocacy in M. Brewster Smith, "Research Strategies toward a Conception of Positive Mental Health," *Am. Psychologist*, vol. 14, no. 11, pp. 673–681, November, 1959.

[53] For documentation, see J. R. Seeley, R. A. Sim, and E. W. Loosley, *Crestwood Heights*, 1956.

[54] A. T. Mason, *Brandeis: A Free Man's Life*, 1946, pp. 245–253.

[55] Rev. P. J. Tillich, "The Impact of Psychotherapy on Theological Thought," address to Academy of Religion and Mental Health, January, 1960.

[56] F. H. Sanford, "Psychology and the Mental Health Movement," *Am. Psychologist*, vol. 13, no. 2, pp. 80–85, 1958.

[57] G. Murphy, *Human Potentialities*, 1958.

PART V

Appendixes

APPENDIX A *Acknowledgments*

A large-scale investigation passes through a series of stages that begins with planning for mobilization and ends years later when, objective achieved, it disbands.

During the years 1950–1951, prior to procurement of support for the Midtown Study, Dr. Rennie consulted a number of knowledgeable people who helped him to crystallize its focus "in broad general terms," as he put it. Among Cornell Medical College colleagues these included Drs. Oskar Diethelm, Alexander H. Leighton, Allister M. Macmillan, Leo Simmons, Wilson Smillie, and Emerson Day. Also important in this stage were Drs. Dorothy Bask, John Clausen, Ernest Gruenberg, Herbert Goldhamer, Molly Harrower, Marie Jahoda, Ann Kent, Seymour Klebanoff, Lawrence Frank, Raymond Mangus, Louis McQuitty, Mellie Simon, Livingston Welch, and, of particular note, Harry Alpert.

Activation of the Midtown Study became a reality with the allocation of grants by the National Institute of Mental Health, the Milbank Memorial Fund, the Grant Foundation, the Rockefeller Brothers Fund, and the Corporation Trust. Without the sustained confidence and support of these agencies and their several boards and executive officers, the project and its embodiment in the memorial volumes to Thomas Rennie would not have reached completion.

Recruitment of personnel to man the multidisciplinary research staff began in the spring of 1952. The selected team members varied not only in professional origin, but also in major function performed for the Study, in weekly time availability, and in duration of service.

First, however, special acknowledgment is due to Dr. Harry Alpert of the University of Oregon (then with the National Science Foundation) and to Dr. Irwin Bross of Roswell Park Memorial Institute (then with the Cornell University Medical College), who at varying intervals served as technical consultants to the Midtown staff during the planning year of June, 1952, to June, 1953. From the latter date to 1959, Bross continued as adviser on methodological problems relating to sampling design and data analysis. His incisive role as critic and catalyst while we tried to push our way through a host of difficulties and complexities cannot be adequately conveyed in this brief note of indebtedness to him.

In addition to Cornell colleagues named above, others consulted in this period were Drs. Phillip McCarthy, Edward Suchman, and Robin Williams. Dr. Robert Bunker served as editorial consultant. To Dr. Max Pepper we are indebted for a critical reading of Chapters 12 and 13.

We here distinguish four categories of staff personnel who were engaged in

the Midtown Study: (1) senior investigators, who (with some exceptions) participated in the planning phases and subsequently had major responsibility to one or another of the four field operations; (2) research aides, principally performing office functions of processing and tabulating field data; (3) interviewers for the Home Survey operation; and (4) volunteers, who carried out miscellaneous field, library, and office functions.

Senior investigators are listed in the order of their appointment to the Study staff. Immediately following each member's name is given his self-defined professional identification, dates of inception and termination of services, and major research responsibility or assignment.

Thomas A. C. Rennie (psychiatrist), 1952–1956: Director, Midtown Study.

Leo Srole (sociologist), 1952–1960: Director, Home Survey operation.

Marvin K. Opler (anthropologist), 1952–1958: Director, Ethnic Family operation (reported in Volume III of this series).

Margaret Bailey (psychiatric social worker), 1952–1955: Treatment Census operation.

Frieda Taran (psychiatric social worker), 1952–1955: Treatment Census operation.

Arthur Weider (clinical psychologist), 1952–1955: questionnaire committee for the Home Survey operation.

Eleanor Leacock (anthropologist), 1952–1955: Assistant Director, Ethnic Family operation.

Price Kirkpatrick (psychiatrist), 1952–1955: mental health evaluation of the Home Survey sample.

Guy La Rochelle (psychiatrist), 1952–1954: Home Survey operation.

Vera Rubin (anthropologist), 1953–1955: Assistant Director, Ethnic Family operation.

Thomas S. Langner (sociologist), 1953–1960: Assistant Director, Home Survey operation; Director, Data Processing and Statistical Analysis for Home Survey and Treatment Census operations.

Stanley T. Michael (psychiatrist), 1954–1960: mental health evaluation of Home Survey sample.

Alexander H. Leighton (psychiatrist), 1956–1960: Director, Midtown Study.

The following list of research aides includes those predoctoral people who were employed by the Study for one or more years: Ann Jezer Avins, Betty Banes, Elliott Camerman, Michel DiLiscia, Allyn Falls, Muriel Grant, Ira Greiff, Jerold Heiss, India Hughley, Merton Hyman, Harold Jarmon, Barbara Kennedy, Dolores Kreisman, Arnold Levine, Anita Lowell, Frances Libby, Sally Pinkerton, Thomas Rick, Irving Silverman, Amorita Suarez, Jan Snaauw, Alice Togo, and Malcolm Willison.

The social workers and social scientists next named completed 25 or more Home Survey interviews: Ruth Balter, Joseph Borello, Marjorie Cantor, Rosemary Dempsey, Helen Halley, John Kupyn, Claire Marck, Robert Marsh, Irene N. Norton, Jess Osterweil, Edmond Pollack, Florence Rothman, Edwin Seda, Esther Shaw, Sol Siegel, Elsie Siff, Ada Slawson, Robert M. Slawson, Janet Sperber, Isidore Weider, and Rosalind Zoglin. Shepard Wolman and Edwin Fancher were supervisors of the interviewing staff. Graduate students in the New York School of Social Work, under the guidance of Margaret Bailey, were instrumental in pretesting several versions of the interview questionnaire.

A total of 99 voluntary workers were secured for the Study through Mrs. Margaretta W. Treherne-Thomas, Director, Volunteer Department of the

New York Hospital–Cornell Medical Center. The volunteers listed below met the criterion of contributing in excess of 500 working hours: Renee Apfelbaum, Maurice Bloch, Tillie Drucker, Lewis Faron, Warren Fox, Leila Freedberger, Mrs. Leonard Frutkin, Mrs. Howard Harris, Rene Hoguet, Percy Perkins, Kurt Porges, Eva Profeta, Samuel Reber, and Mrs. Oakleigh Thorne. Special volunteers were Judith Bernays Heller, Esther A. Srole, and Philip C. Haydock. Appreciation is also due Dr. Alfred Parsell and his students in the department of sociology, City College of New York, for assistance in the youth aspects of the Study's Sociography operation.

Grateful acknowledgment is expressed to the publishers who generously granted permission to draw on extensive passages from the following sources:

Hamilton Basso, *The View from Pompey's Head,* Doubleday & Company, Inc., New York, 1954.

Dorothy Barclay, *Understanding the City Child,* Franklin Watts, Inc., New York, 1959.

John A. Clausen, *Sociology and the Field of Mental Health,* Russell Sage Foundation, New York, 1956.

———, "The Sociology of Mental Illness," in R. K. Merton et al. (eds.), *Sociology Today,* Basic Books, Inc., New York, 1959.

E. J. Cleveland and W. D. Longaker, "Neurotic Patterns in the Family," in A. H. Leighton et al. (eds.), *Explorations in Social Psychiatry,* Basic Books, Inc., New York, 1957.

The Commonwealth Fund, *Chronic Illness in a Large City: The Baltimore Study,* Harvard University Press, Cambridge, Mass., 1957.

Oscar Handlin, *The Uprooted,* Little, Brown & Company, Boston, 1951.

Granville Hicks, *Small Town,* The Macmillan Company, New York, 1946.

A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness,* John Wiley & Sons, Inc., New York, 1958.

Irving L. Janis, *Psychological Stress,* John Wiley & Sons, Inc., New York, 1958.

Max Lerner, *America as a Civilization,* Simon and Schuster, Inc., New York, 1958.

B. Malzberg and E. S. Lee, *Migration and Mental Disease,* Social Science Research Council, New York, 1956.

E. B. White, *Here Is New York,* Harper & Brothers, New York, 1949.

Thomas Wolfe, *The Web and the Rock,* Harper & Brothers, New York, 1939.

The frontispiece portrait of Dr. Rennie appears by courtesy of the photographer, Dr. Peter F. Ostwald.

Other notes of appreciation have already appeared at appropriate points in the chapters above. Our greatest debt of gratitude is reserved for the many unnamed residents of Midtown who selflessly gave themselves as representative specimens in the service of research and the commonweal.

APPENDIX B *Thomas A. C. Rennie's Publications in Social Psychiatry*

BOOKS

Jobs and the Man (with L. E. Woodward), Charles C Thomas, Publisher, Springfield, Ill., 1945.

Mental Health in Modern Society (with L. E. Woodward), the Commonwealth Fund, New York, 1948.

Vocational Rehabilitation of Psychiatric Patients: A Study of Post-hospital Vocational Work (with Temple Burling and Luther E. Woodward), the Commonwealth Fund, New York, 1950.

Vocational Services for Psychiatric Clinic Patients (with Mary F. Bozeman). Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass., 1952.

ARTICLES

"The Rehabilitation Clinic of the New York Hospital," *Cornell Univ. Med. Coll. Quart.*, November, 1943.

"National Planning for Psychiatric Rehabilitation," *Am. J. Orthopsychiat.*, vol. 14, no. 3, 1944.

"A Plan for the Organization of Psychiatric Rehabilitation Clinics," *Mental Hyg.*, vol. 28, no. 2, April, 1944.

"Experiments in a Psychiatric Rehabilitation Clinic for Ex-service men," *J. Med. Soc. City N. Y.*, vol. 3, no. 24, June 10, 1944.

"Rehabilitation of the Psychoneurotic," *Proceedings of the Annual Meeting of the National Council on Rehabilitation*, New York, June, 1944.

"Community Organization for Meeting Problems of Psychiatrically Disabled Veterans" (with L. E. Woodward), Round Table on Rehabilitation, *Am. J. Orthopsychiat.*, vol. 14, no. 4, October, 1944.

"Psychiatric Rehabilitation Therapy," *Am. J. Psychiat.*, vol. 101, no. 4, January, 1945.

"The Rehabilitation of the Psychiatric Casualty" (with L. E. Woodward), *Mental Hyg.*, vol. 29, no. 1, January, 1945.

"The New York Hospital Offers a Pattern for Rehabilitation," *Mod. Hosp.*, vol. 64, no. 4, April, 1945.

"Psychiatric Rehabilitation Resources," *Proceedings of the American Neurological Association*, 1945.

"Psychiatric Rehabilitation Techniques: Current Therapies of Personality Disorders," *Proceedings of the American Psychopathological Association,* 1946.

"Mental Hygiene," *Social Work Year Book,* 1947.

"Toward Industrial Mental Health: An Historical Review" (with Gladys Sockhamer and Luther E. Woodward), *Mental Hyg.*, vol. 31, no. 1, January, 1947.

"Vocational Rehabilitation of the Psychiatrically Disabled" (with Temple Burling and Luther E. Woodward), *Mental Hyg.*, vol. 33, no. 2, April, 1949.

"The Veterans Administration Shows the Way," *Mental Hyg.*, vol. 35, no. 3, July, 1951. Presented at the Annual Conference of the National Association for Mental Health, New York, Nov. 17, 1950.

"Rehabilitation Problems and Services in the Community" (with Mary F. Bozeman). Presented at the Conference of the National Rehabilitation Association, Oct. 25, 1950. Published in Conference Proceedings.

Introductory chapter to American edition of *Mental Health and Human Relations in Industry,* by Thomas Ling, M.D., Paul B. Hoeber, Inc., New York, Medical Department of Harper & Brothers, 1954.

"Social Psychiatry: A Definition," *Intern. J. Social Psychiat.*, vol. 1, no. 1, Summer, 1955.

"The Rehabilitation of the Mentally Ill," *The Elements of a Community Health Program,* 1955.

"Social Class Prevalence and Distribution of Psychosomatic Conditions in an Urban Population" (with Leo Srole), *Psychosomat. Med.*, vol. 18, no. 6, November–December, 1956.

APPENDIX C *Incidence versus Prevalence of Treated Mental Illness*

The largest morbidity study ever undertaken has been that conducted by the United States National Health Survey (NHS) of the Federal Public Health Service. Within its broad reach the NHS covered 12 categories of "acute" somatic conditions, e.g., infectious diseases, and 17 kinds of chronic disorders.

This authoritative government investigation has uniformly applied the *incidence* measure to the acute illnesses, which are relatively brief in duration, and the *prevalence* yardstick to the chronic conditions, characteristically of prolonged duration.[1]

That prevalence is the indicated measure of choice for chronic illness is further seen in the unequivocal statement of medical epidemiologists working in the field of cardiac disorders: "The cardinal statistic in the epidemiology of rheumatic heart disease is the overall prevalence rate." [2]

Although mental illness is an example par excellence of chronic morbidity, the dominant tendency of researchers in this field, transfixed by the acute diseases as seemingly appropriate analytical models, has long been to embrace the unequivocal and unqualified position that "the incidence rate is the fundamental epidemiological ratio." [3] The extremity of this position is reflected in one professional book review[4] of the New Haven Psychiatric Census monograph by Hollingshead and Redlich.[5] In the latter work, the epidemiological aspect was largely carried out in terms of prevalence, with minor utilization of the novel Yale modification of the incidence yardstick. Yet the reviewer dismissed the voluminous New Haven prevalence findings as seemingly beneath discussion and focused almost entirely on the slender incidence data from New Haven.

The key to this bias is the reviewer's contention that incidence is a "measure of the amount of mental illness generated during a standard period." As do advocates of the prevalence yardstick, the proponents of the incidence measure tend to use *treated* psychiatric cases as if they represented the totality of mentally sick people, or at least an acceptable approximation of that universe. However, the incidence partisans, proceeding from the model of the acute somatic disorders, also seem to assume (1) that mental illness generally has a specific point of onset, (2) that admission to treatment (usually to a mental hospital) tends to occur at a time not distant from the point of onset, and (3) q.e.d. the number of such "first" admissions during the course of a given year can be accepted as a measure of the amount of mental illness *generated* during that period.

These assumptions do not stand up under critical inspection. First, like other chronic disorders, mental illness as a rule proliferates slowly from a more or less asymptomatic stage. In other words, the break into an open psychosis, far from

being the onset of the disease process, is no more than a culmination; the neuroses and character disorders, to complicate matters, may present no sharply delineated break of any kind. Unlike the acute illnesses, therefore, point of onset in mental morbidity is often beyond determination or highly equivocal.

Second, even with the psychotic break as a definable landmark, the manifest illness may be severe and brief or mild and prolonged. The former type generally gets to treatment more often than the latter. One study, focused on chronic first-admission hospital patients, found that only 29% entered the institution within a year of presenting unmistakable psychotic symptoms, whereas 46% entered three or more years after such symptoms had appeared.[6] Similarly, Clausen reports: "In our own research on the families of mental patients, we have encountered instances in which an accepting and nurturant wife has been able to sustain a schizophrenic spouse for 5–10 years before [securing treatment]." [7] From a study of hospitalized patients, C. A. Whitmer has indicated that not psychosis as such leads to institutionalization, but rather a turn of the overt but harmless psychotic toward "dangerous or unmanageable behavior that threatened the family or the community." [Personal communication.] In short, if a point of illness onset *were* definable it would bear little regularity of proximity relative to initiation of treatment as a second point of time.

Furthermore, institutional files, being what they are, often default in recording whether or not a patient (particularly if he is in short-term treatment) is a first admission. Most serious of all, the first-admission criterion of illness onset crumbles completely when we see that it refers to cases new only to a particular institution or hospital system. Many Treatment Census patients listed as a first admission in the New York state hospital system were variously found to have been treated for years previously by an office therapist, an outpatient clinic, a private hospital, a public hospital in another state system, or some combination of these. The effort to equate such a New York state hospital first admission with onset of illness descends to the level of the unfathomable.

Even if all of the above deficiencies were not involved, there is still the question of the meaning of differences in incidence (of treatment) rate between two populations. By way of one example, the incidence rate is usually calculated with the number of newly treated cases during a given *year* as the numerator and the total population resident in the area on *any given day* as the denominator. Now let us imagine two urban areas each with 100,000 residents on the United States decennial census day. Area A has an annual incidence of 100 hospitalized patients and area B of 150 such patients—a seemingly meaningful difference.

However, area A is a stable section of homeowners only, with little population turnover; i.e., it actually housed few more than 100,000 people all told during the course of the study year. Area B, on the other hand, is entirely a section of short-lease apartments, apartment hotels, and rooming houses with large inflow and outflow of transient residents. During the year this area may actually have housed a total of 150,000 people. Thus, area A's 100,000 residents during the year yielded 100 patients, and B's 150,000 residents during the year yielded 150 patients, the two now defining an *identical rate* of 100 per 100,000 population at risk.

The fact is, however, that the United States census has *not* provided more than a *prevalence* count of residents as of a *single* day. Accordingly, the conventional annual incidence rate rests on an inappropriate population base as its denominator value. On all these critical grounds, among others, we reluctantly concluded that use of the incidence rates produced by the Midtown

Treatment Census would be indefensible.

As this volume abundantly shows, the patient prevalence measure is itself an inadequate foundation of evidence for generalizing about *over-all* (untreated and treated) prevalence of mental illness.

FOOTNOTES

[1] *Health Statistics from the U.S. National Health Survey: Diabetes,* ser. B, no. 21, 1960; and *Acute Conditions,* ser. B, no. 23, 1960.

[2] J. Stokes, III, and T. R. Dawber, "Rheumatic Heart Disease in the Framingham Study," *New Engl. J. Med.,* vol. 225, no. 26, p. 1228, Dec. 27, 1956.

[3] M. Kramer, "A Discussion of the Concepts of Incidence and Prevalence as Related to Epidemiological Studies of Mental Disorders," *Am. J. Public Health,* vol. 47, no. 7, p. 827, July, 1957.

[4] *Am. Sociological Rev.,* August, 1959.

[5] A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness,* 1958.

[6] N. C. Morgan and N. A. Johnson, "Failures in Psychiatry: The Chronic Hospital Patient," *Am. J. Psychiat.* vol. 113, no. 2, pp. 824–830, March, 1957.

[7] J. A. Clausen, "Ecology of Mental Disorders," in *Symposium on Preventive and Social Psychiatry,* Walter Reed Army Institute of Research, 1958, p. 107.

APPENDIX D *Further Checks of Home Survey's Sample of Respondents*

In Table 3-1 we have been able to compare the sex-specific age distributions among (1) the Home Survey's complete sample of 1,911 individuals drawn for interviewing, (2) the survey's 1,660 sample individuals actually interviewed during the first half of 1954, and (3) the Midtown age 20 to 59 population universe as enumerated by the U.S. Census Bureau in April, 1950. The age and sex composition of the Midtown population universe was derived from publications of the Census Bureau. However, in reporting other demographic distributions, these publications do *not* circumscribe the data in terms of the 20 to 59 age boundaries we had defined for the Home Survey's population universe. As it happened, we had commissioned the U.S. Census Bureau in Washington to perform special tabulations for purposes of our Treatment Census operation and its particular rate-calculation needs. The Bureau had available the IBM cards of 20% of all Americans enumerated by the 1950 census. Culling out the Midtown residents' cards from this sample, the Bureau at our specification sorted them by age and sex and cross-tabulated these subgroups on certain other demographic factors, namely, race, generation-in-U.S., national origin, and education. These tabulations could be put to use in checking the demographic composition of our Home Survey sample within the circumscribed age 20 to 59 boundaries.

We would emphasize, however, that distributional correspondence between this U.S. Census Bureau 20% sample (of age 20 to 59 Midtowners) and our Home Survey sample was not expected to be exact. Obviously, four years separated the Census Bureau sample from the latter, and accumulated local and general changes had registered on the Home Survey sample, as we shall presently see in more detail. Second, both samples are subject to sampling variance due to chance fluctuations in the random selection process. Thus, any distributional differences of about 3% or less found between the Census Bureau sample and the Home Survey sample are likely to be a function of chance, and accordingly of no apparent significance. Finally, Census Bureau data are subject to errors arising from the fact that its decennial operation is enormous in scope and necessarily executed by temporary workers who are in the main non-professionals.[1] Nonetheless, a general concordance among the three indicated samples may offer firmer grounds for confidence in the Home Survey respondent sample than correspondence between the latter and any other one sample. The results may be inspected in Table D-1.

Comparing the columns on the five factors included in Table D-1, we note only one divergence greater than 3%. This minor exception aside, all three samples appear to be in striking agreement in their distributions.

Table D-1. Sex, Generation, Race, and National-Origin Composition of Midtown Population Universe and Samples, Age 20–59 Only

(In percentages)

	Census Bureau 20% sample (1950)	Home Survey complete sample (1954)	Home Survey interviewed sample (1954)
Total persons 20–59 years of age	109,000	1,911	1,660
Per cent	100%	100%	100%
Sex:			
Male	44.2%	42.2%	41.6%
Female	55.8	57.8	58.4
	100.0%	100.0%	100.0%
Generation-in-U.S.*			
Generation I	35.1%	33.4%	34.4%
Generation II	32.5	....†	34.3
Generation III+ ‡	32.4	....†	31.3
	100.0%		100.0%
National origin, generation I			
Germany-Austria	29.0%	27.9%	28.7%
Ireland	17.2	13.6	13.8
Italy	7.1	7.2	7.0
Hungary	7.0	8.0	7.9
Czechoslovakia	8.9	11.4	10.5
Russia, Poland, Lithuania	6.0	7.1	7.2
England, Wales, Scotland	6.4	6.1	6.5
Other ethnic groups	18.4	18.7	18.4
	100.0%	100.0%	100.0%
National origin of parents, generation II			
Germany-Austria	19.2%	....†	19.5%
Ireland	18.0	....	16.5
Italy	13.7	....	16.6
Hungary	6.9	....	4.7
Czechoslovakia	11.1	....	9.7
Russia, Poland, Lithuania	13.8	....	15.0
England, Wales, Scotland	5.1	....	5.7
Other ethnic groups	12.2	....	12.3
	100.0%		100.0%
Race: Nonwhites as per cent of total	0.5%	0.5%	0.7%

* Generation I includes foreign-born; generation II includes native-born of foreign-born parentage; generation III+ includes native-born of native-born parentage.

† In the case of many U.S.-born nonrespondents, it was not possible to secure information on parents' nativity or national origin.

‡ According to law, the Census Bureau classifies all Puerto Ricans as native-born of native-born parents, i.e., generation III+. To effect comparability on this point, we have here followed the Bureau's example in classifying Puerto Ricans drawn into the Home Survey samples. Elsewhere in this book, however, we consistently place migrants from Puerto Rico in generation I and their mainland-born children in generation II. Thereby, the generation distribution of the interviewed Home Survey sample appearing in other chapters will not be identical with that given here.

Census Bureau publications report education composition only for the population segment above the age of 24. We have therefore conformed with this practice in Table D-2 by focusing on Midtown's 25 to 59 age range, made available in the Bureau's special tabulations for us.

Table D-2. Education Composition of Midtown Population Universe and Samples, Age 25–59 Only

	Census Bureau 20% sample (1950)	Home Survey complete sample (1954)	Home Survey interviewed sample (1954)
Total persons 25–59 years of age.....	97,031	1,738	1,503
Per cent.....	100%	100%	100%
Education level:			
Elementary (or no) school.....	42.3%	33.7%	32.2%
High school.....	36.0	38.1	38.6
College.....	21.7	28.2	29.2
	100.0%	100.0%	100.0%

We see here a familiar phenomenon, namely, the almost invariable tendency of surveys to show a more advanced educational standing in their sample than did the Census Bureau for the sample's population universe. Comparing the two Home Survey samples (1954) with the Census Bureau sample (1950), we observe that the latter seems to have significantly fewer college people and correspondingly more of those who did not go beyond the elementary school level.

However, to partially account for these differences, we might consider consequences of the fact that Midtowners who in 1950 were between the ages of 25 and 59 had by 1954 approximated an age range of 29 to 63. Those who had crossed the 60-year mark in the interim had passed beyond the reach of the Home Survey sampling apparatus activated in 1954. And in the same interval, many of the 1950 adolescents had come into the universe of the Home Survey sample. The education difference between the new recruits and the aging exmembers of this universe is considerable, as is suggested by the 1950 census finding that not educated beyond the elementary school level were 56% of age 55 to 59 Midtowners and only 15% of their age 25 to 29 neighbors.

To take account of this inexorable life-cycle shift and its education concomitant in the Census Bureau's 1950 sample, we next focused on its age 25 to 54 segment. By the time of the Home Survey operation, these Midtown people were close to the age 30 to 59 range. To these we arithmetically added the Midtown segment which in 1954 was within the 25 to 29 age range, assuming in so doing that its schooling composition was more or less equivalent to that of the age 25 to 29 group during the 1950 census. Joining the two segments yielded an education distribution for the age 25 to 59 range in 1954 that we estimate as follows:

Elementary (or no) schooling...	33.8%
High school.....	41.6
College.....	24.6
	100.0%

Aligning this distribution with the Home Survey samples in Table D-2 we see that all three 1954 samples are now almost identical in their representation of elementary school people. And the proportions of college-trained Midtowners in the adjusted Census Bureau sample and Home Survey's complete sample have narrowed to the difference between 24.6 and 28.2%. This appears to be somewhat larger than a chance error. And even this "beyond chance" margin can be accounted for by Midtown's transformation between 1950 and 1954 of low-rent housing and nonresidential structures into sites of peak-rent apartment buildings. Independently of the concurrent life-cycle shift, but with like results, this change in effect substituted more-educated newcomers for the less-educated who were forced out by demolition crews. Accordingly, the schooling composition of the Home Survey interviewed sample may in this respect be more representative of the area's age 20 to 59 population universe in 1954 than was Midtown's corresponding universe four years earlier.

Taken over-all, the seven demographic factors presented in Table 3-1, D-1, and D-2 attest to the consistently close correspondence between the two 1954 Home Survey samples and the U.S. Census Bureau sample of Midtown's 1950 age-delimited population universe.

However, internal analysis of the Home Survey interviewed sample yielded only one seeming anomaly that could reflect on the adequacy of that sample. According to random selection procedures, the respondent sample should have included as many wives as husbands (excluding in both instances the separated, divorced, and widowed). Age-controlled analysis, shown in Table D-3, reveals that this expectation is not completely fulfilled.

Table D-3. Proportions of Husbands and Wives in Midtown Sample of Respondents by Age Levels

	Age groups			
	20–29	30–39	40–49	50–59
Husbands	35.0%	45.4%	48.0%	50%
Wives	65.0	54.6	52.0	50%
N = 100%	(172)	(249)	(295)	(270)

The only pronounced deviation from theoretical expectation is localized in the youngest age group, in which wives outnumber husbands by a ratio of almost 2:1. However, this seemingly improbable ratio assumes another aspect when we consider several intertwined processes. The first is that husbands predominantly tend to be older than their own spouse, by an average of almost 3 years. Thus, a wife in the 20 to 29 age group may well have a husband in the 30 to 39 age range. The plain inference is, therefore, that there are more wives than husbands in the age 20 to 29 segment of the population universe.

Second, and beyond this fact, more age 20 to 29 husbands than wives are likely to be temporarily parted from spouse on a "career leave," e.g., in military or government service, or in professional school or job training programs elsewhere. To this extent, fewer of these husbands would be drawn into the respondent sample than might be expected from the number of resident like-age wives.

Together the two processes just discussed suggest that the 1:2 ratio of husbands and wives in the age 20 to 29 group of respondents reflects in the

main not a defect in sampling design or execution, but rather an actual condition in the population universe. (Census Bureau publications report marital status only for the broad span of the population at age 14 or over). By meeting the challenge of the above seeming anomaly in sample composition, and by the series of checks made against the Home Survey's complete sample and appropriate United States census data, published and unpublished, we can document our confidence in the representative accuracy of the Home Survey's interviewed sample of Midtown adults.

FOOTNOTES

[1] M. H. Hansen, W. N. Hurwitz, and L. Pritzker, "The Accuracy of Census Results," *Am. Sociological Rev.*, vol. 18, no. 4, pp. 416–423, August, 1953. These writers tell us: "The fact that a small well-designed and well-administered sample can yield more accurate measurements than is feasible in the much larger scale operations required for a census suggests the use of the former as a vehicle for checking on the latter. In fact, the Bureau of the Census and other statistical agencies have used this second approach to study the accuracy of censuses." See also G. Chevry, "Control of a General Census by Means of an Area Sampling Method," *J. Am. Statist. Assoc.*, vol. 44, no. 247, pp. 373–379, 1949.

APPENDIX E *Interview Summary Form for Study Psychiatrists*

The contents of the questionnaire employed to interview the Midtown sample respondent have been reviewed at some lengths in Chapters 3 and 4. That instrument, 65 pages long in mimeographed format, cannot be reproduced here in its entirety.

Further discussion of the mental health ratings assigned to Midtown respondents follows in Appendix F. Reference is there made to the interview Summary prepared in highly compact and readily encompassable format for the use of Study psychiatrists. The Summary form, to which the office staff in condensed wordage transferred relevant items of information from the respondent's protocol, is reproduced below substantially as presented to the psychiatrists. Also incorporated are the original code numbers for items referred to in Appendix F. The respondent is designated "R."

Part I

W13–1. Height 4′ or less 2. (4′1″–4′4″) 3. (4′5″–4′8″) 4. (4′9″–5′) 5. (5′1″–5′4″) 6. (5′5″–5′8″) 7. (5′9″–6′) 8. (6′1″–6′4″) 9. (6′5″ and over)

W14–1. Weight 89 lb or less 2. (90–109) 3. (110–129) 4. (130–149) 5. (150–169) 6. (170–189) 7. (190–209) 8. (210–249) 9. (250–299) 0. (300 or over)

W15–1. Age 20–24 yrs. 2. (25–29) 3. (30–34) 4. (35–39) 5. (40–44) 6. (45–49) 7. (50–54) 8. (55–59)

W15–X. Male Y. Female

W16–1. Married 2. Never married 3. Widowed 4. Divorced 5. Separated

N27–1. Married once 6. Twice 7. Three or more times

N28–1. Under 15 when married 2. (15–19) 3. (20–24) 4. (25–29) 5. (30–34) 6. (35–44) 7. (45–59)

W18–1. Health excellent now 2. Good 3. Fair 4. Poor

W18–7. Health now same as 4–5 yrs ago 8. Health now better 9. Health not as good

W19–43. Conditions (arthritis, asthma, bladder, colitis, diabetes, hay fever, heart condition, hypertension, neuralgia, nervous breakdown, epilepsy, ulcer, skin trouble)

R5–1. Appetite poor 2. Fair

R5–8. Stomach upset pretty often 9. Nearly all the time

R6–1. Headaches often 2. Sometimes

R6–6. Sleep trouble often 7. Sometimes

R7–1. Hands damp often 2. Sometimes
R7–6. Hands tremble often 7. Sometimes
R8–1. Shortness of breath often 2. Sometimes
R8–6. Heart beats hard often 7. Sometimes
R9–1. Cold sweats often 2. Sometimes
R9–7. Dizziness a few times 8. More than a few times
R10–2. Fainting a few times 3. More than a few times
R10–6. Nervousness often 7. Sometimes
R11–9. Other ailments _____
R14–6. Smoke too much
R15–6. Drink coffee too much
R16–6. Drink liquor too much
R17–2. Eat too much
R17–6. Feel weak all over
R18–1. Such restlessness, can't sit long in a chair
R18–5. Bothered by sour stomach several times a week
R18–0. Memory is not all right
R19–1. Every so often feel hot all over
R19–5. Periods of days, weeks, months when couldn't get going
R19–9. Pains in back interfere with work
R20–1. Often have hard time making up my mind about things I should do
R20–5. Often have a clogging in my head or nose
Q 29 A. No. of med. specialists seen_____

R25–3. Childhood health poor
R25–8. Birth defects _____
R26–5. Childhood trouble—sleep
R26–9. Childhood trouble—stammer or stutter
R27–1. Childhood trouble—upset stomach fairly often

Childhood Fears of

R27 Strangers 6. Little 7. Much
R28 Thunder 2. Little 3. Much
R28 Being left alone 8. Little 9. Much
R29 High Places 2. Little 3. Much
R29 Animals 8. Little 9. Much
R30 Being laughed at 2. Little 3. Much
R31 Being bawled out 2. Little 3. Much

R45–2. Is worrying type

B11–1. Dated opposite sex more often than others did 2. About same 3. Less often
B14–7. Liked school very much 8. All right 9. Disliked 0. Hated

G5–1. One should do everything perfectly
G5–5. One drink is one too many
G5–9. Never show feelings to others
G6–1. Never change mind
G6–5. Always be on guard with people
G7–1. Often, old ways are best ways
G7–5. Prefer to go out by myself
G7–9. Feel somewhat apart even among friends

G8–1. Keep my opinions to myself
G8–5. Feel people are against me
G8–0. Not had my share of good luck
G9–1. Most of the time in high spirits 3. Low spirits 4. Very low spirits
G40–2. Life gives a lot of pleasure—Disagree
G40–5. People talk behind your back
G40–9. Nothing turns out right for me
G41–1. In marriage the woman sacrifices more than the man
G41–5. At times a person feels he is a stranger to himself
G41–9. The unmarried can be just as content as the married
G42–1. Most people think a lot about sex
G42–5. Personal worries get me down physically
G43–1. Sometimes wonder if anything is worthwhile
G44–1. Can't enjoy myself when alone
G44–5. High buildings, tunnels, bridges make me tense (nervous)
G44–9. One should retire at same time each night
A5–1. I rarely make a mistake
A5–5. Don't care what others think of me
A5–9. When I want something very much I want it right away
A6–1. Am a gambler at heart
A6–5. No one really understands me
A6–0. I don't always take good care of my health
A7–6. Often worry—loneliness
A10–6. Often worry—old age
A11–1. Often worry—atom bomb
A11–6. Often worry—personal enemies
A12–1. Often worry—health
A24–1. Better do things on spur of moment than plan ahead
A24–5. No right and wrong, only easy and hard ways to make money
A24–9. Grief and sorrow not for adults
A25–1. Better to keep away from family
A27–2, 3, 4, 5, 6 Hospitalized conditions_____
A29–2, 3, 4, 5, 6 Clinic conditions _____

Interviewer's Observations

A34 R's interest at start 1. Lack 2. Mild 3. High
A34 R's interest at close 5. Lack 6. Mild 7. High
A34 R's tension level at start 9. Nervous 0. Sporadic nervous X. Mostly relaxed
A35 R's tension level at close 1. Nervous 2. Sporadic nervous 3. Mostly relaxed
A35 Distractions during interview 5. Much 6. Some 7. None
A36 R's attitude 1. Hostile 2. Suspicious 3. Friendly 4. Solicitous
A36 Responses 6. Inappropriate, irrelevant, rambling 7. Vague, facetious, dull 8. Alert 9. Overtalkative (appropriate content)
A37 Affect or mood 1. Depressed 2. Apathetic 3. Normal 4. Cheerful
A37 Alertness-intelligence 6. Dull 7. Slow 8. Average 9. Above average
A38 Appearance 1. Sloppy 2. Untidy 3. Neat 4. Overly neat
A38 Physical defects 6. Muscular tic 7. Stutter 8. Memory difficulties 9. Cosmetic deformity 0. Gross physical difficulty X. Other

Scores on Symptom Dimensions

Immaturity M52–0 1 2 3 4 5 6 7 8 9
Rigidity M53–0 1 2 3 4 5 6
Frustration-Depression M54–0 1 2 3 4 5

Excess intake M55–0 1 2 3 4
Tension-Anxiety (Short form) M56–0 1 2 3 4 5
Neurasthenia M57–0 1 2 3
Appetite-Stomach M58–0 1 2 3
Headaches M59–0 1 2 3
Vasolability M60–0 1 2 3
Other organs M61–0 1 2 3 4 5
Suspicious M62–0 1 2 3 4
Withdrawal M63–0 1 2 3 4
Adult Anxiety Dimension M64–0 1 2 3 4 5 6 7 8 9
M64–10 11 12 13 14 15 16 17 18
Childhood Anxiety Dimension M65–0 1 2 3 4 5 6 7 8

Part II

W8–1. One in household 2. two 3. three 4. four 5. five 6. six 7. seven 8. eight 9. nine 0. ten+
W9 Kin composition 1. Husband 2. Wife 3. Father 4. Mother 5. Children 0. Other Kin X. Non-kin
W17–1. No children 2. One 3. Two 4. Three 5. Four 6. Five–Eight 7. Nine–Twelve
R11–1. Race—White 2. Negro 3. Other

R30 As child feared family quarrels 8. Little 9. Much
R32–1. No brothers 2. One 3. Two 4. Three–Four 5. Five+
R32–7. No sisters 8. One 9. Two 0. Three–Four X. Five+
R33–1. First sibling 2. Second 3. Third 4. Fourth 5. Fifth 6. Last 7. Other _____ 8. No sibs
R36–2. Not raised by both parents
R37–1. What happened—death of father 2. Death of mother 3. Divorce 4. Separation 5. Desertion by father 6. Desertion by mother 7. Father in hospital 8. Mother in hospital 9. Lived away from parents 0. Other
R38–1. R's age at separation—under 1 yr. 2. (1–3) 3. (4–6) 4. (7–9) 5. (10–12) 6. (13–15) 7. 16+
R39–1. Raised by remaining parent 2. Grandparent 3. Step-parent 4. Foster parents 5. Aunt-Uncle 6. Institution 7. Other
R40–2. Remaining parent remarried
R41 R's age when parent remarried. 1. Under 1 yr. 2. (1–3) 3. (4–6) 4. (7–9) 5. (10–12) 6. (13–15) 7. (16+)
R42–1. Got along with substitute parent(s) well 2. Not so well 3. Not at all
R43–5. Poor health—Mother 6. Father 7. Both
W44–50 Kin's psychosomatic conditions _____
R44 Parents worrying type 5. Mother 6. Father 7. Both
R45–5. R takes after—Mother 6. Father 7. Both 8. Other _____
R46–1. Discord between parents—often 4. Never
R46–7. R had discord with parents often 0. Never
R47–1. Disagreement over free time 6. Religion
R48–1. Disagreement over food 6. Money
R49–1. Disagreement over going out with girls (boys) 6. Schoolwork
R50–1. Disagreement over what to do when sick 6. Deciding things for self
B5–1. Disagreements mainly with father 2. Mother 3. Both

B6–1. Parents had no problems while R 6–18 yrs. 2. Unemployment 3. Work 4. Financial 5. Father-mother conflict 6. Illness 7. Myself 8. Siblings 9. Other kin 0. Father inadequate X. Mother inadequate Y. Housing

As child felt that—
B7–7. Parents behind the times
B8–1. Father spends too little time with me. 5. Mother wants to run children's lives 9. Home is where people get in each other's way
B9–1. Parents always proud of children 5. Mother does not understand me 9. Parents don't practice what they preach
B10–1. Father wants to run children's lives 5. Parents want me to do things better than other children 9. I'm happy only when at home

B12 R's educ. 1. None 2. Gs 3. Hs 4. HSG 5. Col 6. Col grad 7. Postgrad
B15 Father's educ. 1. None 2. Gs 3. Hs 4. HSG 5. Col 6. Col grad 7. Postgrad
B16 Mother's educ. 1. None 2. Gs 3. Hs 4. HSG 5. Col 6. Col grad 7. Postgrad
B17 Spouse's educ. 1. None 2. Gs 3. Hs 4. HSG 5. Col 6. Col grad 7. Postgrad

B18 During R's childhood parents had hard time making ends meet 5. Often 6. Sometimes
B21–7. Mother worked full time 8. Part time
B22 Father's occupation when R 8–9 yrs. _____
B23 Father's occupation when R 18–19 yrs. _____
B24–2. Father's occupational aspirations for R _____
B26–2. Mother's occupational aspirations for R _____
B28 R's occupational aspiration at end of schooling _____
B35 Occupation R now feels best suited for _____

Married Women

B37 Husband's occupation _____
B38–1. R is working full time 2. Part time
B38 Reason for working 6. Earn money 7. Have career 8. Get out of house 9. Other _____
B39 R's occupation _____
B40–1. Likes work very much 2. Fairly much 3. Not so much 4. Not at all
B41–2. R's health upset by work

Men or Single Women

B42–1. R working 2. R out of work 3. R retired 4. R student 5. Other _____
B43 R's occupation _____
B44 R in how many other lines of work before? 6. One 7. Two 8. Three 9. Four 0. Five+
B45–1. Likes work very much 2. Fairly much 3. Not so much 4. Not at all
B46–2. R's health upset by work
B47–2. R had to stop work for health reasons

B48–2. R's wife working

B49 Wife's occupation _____
N12–0. Father's religion—Catholic X. Jewish Y. Protestant 9. Gk. Orthodox 8. Other_____
N13–0. Mother's religion—Catholic X. Jewish Y. Protestant 9. Gk. Orthodox 8. Other_____
N15–0. R's religion—Catholic X. Jewish Y. Protestant 9. Gk. Orthodox 8. Other_____
N16–0. Spouse's religion—Catholic X. Jewish Y. Protestant 9. Gk. Orthodox 8. Other_____
N18–1. Religion very important 3. Not at all important
N19–2. Churchgoer_____
N23–1. R born U.S. 2. Ger.-Aus. 3. Ireland 4. Italy 5. Hung. 6. Czech. 7. Russ.-Pol.-Lith. 8. Puerto Rico 9. Eng.-Scot.-Wales 0. Other _____
N 25 Age came to U.S. 1. Under 6 yrs. 2. (6–11) 3. (12–17) 4. (18–24) 5. (25–44) 6. (45+)
N26–1. Spouse born U.S. 2. Ger.-Aus. 3. Ir. 4. It. 5. Hung. 6. Cz. 7. Russ.-Pol.-Lith. 8. Puer. R. 9. Eng.-Scot.-Wales 0. Other _____
N31. Where father born _____
N32. Where mother born _____
N39–1. Generation I 2. (II–O) 3. (II–M) 4. (II–X) 5. (III–O) 6. (III–M) 7. (III–X) 8. (III–R) 9. (IV+)
G11. Age R came to N.Y.C. 1. (1–4) 2. (5–9) 3. (10–14) 4. (15–19) 5. (20–24) 6. (25–29) 7. (30–34) 8. (35–39) 9. (40+) 0. R born in N.Y.C.
G22–1. One address since age 18 2. Two 3. Three 4. Four 5. Five 6. Six 7. Seven 8. Eight 9. Nine 0. Ten+
G26–1. Income under $65/month 2. ($65–99) 3. ($100–199) 4. ($200–319) 5. ($320–429) 6. ($430–539) 7. ($540–649) 8. ($650–749) 9. ($750–859) 0. ($860–1,299) X. (1,300+)
G32. Number of neighbors visited 1. (none) 2. (one) 3. (2–3) 4. (4–5) 5. (6–9) 6. (10+) 7. (Other) _____
G33–2. Would like more friends
G34. No. of close friends 1. (none) 2. (one) 3. (2–3) 4. (4–5) 5. (6–9) 6. (10–14) 7. (15+) 8. (Other) _____
G35–1. No leisure activities 2. Mass media 3. Reading 4. Music 5. Arts 6. Outdoor activities 7. Spectator sports 8. Volunteer 9. Other hobby _____ 0. Self-improvement X. Other _____
G37 Active in organizations 1. One 2. Two 3. Three 4. Four 5. Five+
G38–2. R attends meetings
A7–1. Often worry—cost of living
A8–1. Often worry—getting ahead
A8–6. Often worry—my work
A9–1. Often worry—overwork
A9–6. Often worry—marriage
A10–1. Often worry—children
A14–1. Problems with children: physical health 2. Bad companions 3. Delinquent 4. School 5. Child-parent conflict 6. Sib conflict 7. Poor adjustment 8. Habit disturbances 9. Generalized concern 0. Other _____
A15–2. Received advice for child
A16–1. Received advice from relatives 2. Friends 3. Church 4. School 5. Court 6. Doctor 7. Psychiatrist or guidance clinic 8. Psychologist or counselor 9. Social agency 0. Recreational leader X. Other _____

A23–1. R known to Dept. of Welfare 2. Court 3. Mental hospital 4. Social agency 5. Not known 6. Cannot be identified by SSE 7. Not cleared by SSE 8. Known to our Treatment Census 9. Not known to our Treatment Census 0. Seen by Team psychiatrist

A32–1. Interviewer SES rating 1. (A) 2. (B) 3. (C) 4. (D) 5. (E) 6. (F)

A30–5. Hospital plan: Blue Cross 6. Blue Shield 7. HIP 8. Insur. co. 9. Other

---

R. has seen:	Last 30 days	1–12 mos. ago	1–5 yrs.	6–10 yrs.	11+ yrs.
R21–2. Nerve specialist	5	6	7	8	9
R22–2. Psychiatrist	5	6	7	8	9
R23–2. Psychologist	5	6	7	8	9
R24–2. Other therapist	5	6	7	8	9

APPENDIX F *Additional Information on the Mental Health Ratings*

Stanley T. Michael and Price Kirkpatrick

The purpose of this appendix is to provide the interested reader with more specific and detailed information regarding the way the psychiatrists applied the mental health ratings. In particular, attention is given to explanation of the judging process and to the presentation of the complexities and perplexities with which we wrestled. It shows what went on as we converted our raw data to over-all impressions of personality and formulations of the mental health ratings.

In Chapter 4 we set the rating process in context through a presentation of (1) the consideration which led us to prefer a questionnaire interview to clinical examinations; (2) the psychiatrists' participation in developing the questionnaire; (3) the processing of the interview information by staff members for the psychiatrists' consideration; (4) the organization of the Summary record as a section devoid of social functioning data for the assignment of a tentative rating (I) on the basis of symptoms and other psychopathological manifestations alone; and (5) how our separate global ratings (II) for each respondent were combined in a final classification scheme. Chapter 4 reviews further the judges' brief working definition of mental health and the names we assigned to the various levels of health or disturbance. Against such a background, the present Appendix will analyze our practice.

At noted in Chapter 4, we had to maintain awareness that we were not rating clinical cases but rather a predominantly nonpatient population of community residents. To maintain consciousness of this orientation we had to acquaint ourselves with the various formulated concepts of normality.[1] Our criteria for what may ideally be expected of a mature adult were very much those that Rennie had elsewhere described as follows:[2]

> Independence of action, thought, and standards . . . freedom from undue anxiety, freedom from crippling inferiority and guilt feelings, from excessive egotism, and from competitiveness and unbridled hostility . . . concern for others, a respect for differing religions and ethics, an appreciation of one's own liabilities and assets . . . the assumption of adult responsibilities [including] the obligation to find and sustain a satisfying job, to recognize the need for play and rest, and to find satisfaction in one's role as an individual in relation to family, social, and civic life . . . the establishment and maintenance of a home . . . loving and giving to mate and children . . . a capacity to accept illness, disappointments, bereavements, even death and all that which is largely beyond our own control [as well as] our own make-up and individuality, the perfection and imperfections of self and others, success and failure,

sportsmanship, and the social comparisons which we call advice, criticism, and authority . . . a philosophy of objectivity about the past and a vision of creative opportunity for the present and the future . . . the capacity to create and participate in a consensus based on understanding others and on making one's self understood.

However, the personality descriptions presented to the Study's judges in the interview Summary (Part I) were characterized by emphasis on psychiatric symptoms and morbid projections. Even adjustments in social and economic areas (interview Summary Part II) were structured with special consideration of their possible relationship to psychiatric problems. The rating procedure was thus in large part reduced to an evaluation of that part of the personality which betrayed pathology.

Many symptom items of the questionnaire were taken from previously constructed tests designed and validated to screen psychopathology (see Chapter 3). An affirming answer to many of the questions almost automatically excluded the possibility of emotional well-being. It was agreed that no one would be rated well who replied "often" to selected items of the questionnaire usually indicative of significant psychopathology. Anyone who stated that his stomach is upset pretty often or nearly all the time (R5–8, 9 in interview Summary form), that his heart beats hard often (R8–6), or that he has cold sweats often (R9–1) could not be rated Well. If the answer "sometimes" was given to a large series of these items the respondent was also considered potentially neurotic and the rating Well was not applied.

In addition, respondents who replied "yes" to items "drink liquor too much" (R16–6), "feel weak all over" (R17–6), "such restlessness I can't sit long in a chair" (R18–1), "periods of days, weeks, months when I couldn't get going" (R19–5), and "can't make up my mind" (R20–1) were not considered symptom-free. A mental health rating Well was also denied to anyone who replied "yes" to the question "worrying type" (R45–2), "always be on guard with people" (G6–5), "feel people are against me" (G8–5), who said he was in "very low spirits" (G9–4), who disagreed that "life gives a lot of pleasure" (G40–2), and who agreed that "personal worries get me down physically" (G42–5).

Thus we devised a system of flag items, agreement to which by the respondent precluded a rating of good mental health. But these responses could not be used mechanically as punch-card items, although a "yes" answer indicated the presence of a definite symptom. It soon became evident that almost every one of these pathognomonic responses was subject to exception. Thus frequent occurrences of headache, difficulty with sleeping, dampness and tremor of hands, shortness of breath with palpitation and cold sweats, and dizziness and fainting could also be pertinent in a cardiac illness, tuberculosis, or the menopause. Somatic illness had to be taken into consideration before these items could be designated as indicating purely psychiatric symptomatology. But even responses which were not psychosomatic had to be carefully examined for qualifications from remarks obtained in the respondents' spontaneous comments. Thus, a woman who had agreed that there were "periods of days, weeks, and months when she couldn't get going" (R19–5), a symptom usually considered to be indicative of severe emotional disturbance, was not conceded this item when she volunteered that such occurred only once in her life for a duration of approximately three weeks after the accidental death of her husband.

Even the presence of a clearly psychosomatic illness such as hay fever was considered compatible with a mental health rating Well if the symptoms

occurred only rarely and were not disturbing to the individual. Thus one respondent stated that he had hay fever only one or two days each year during the spring, but was not disturbed by the occasional sneezing, which was the basis for the diagnosis and its only symptom.

Ratings other than Well were not so readily circumscribed or defined, and consequently the rating depended more on the interpretation by the individual psychiatrist. Nevertheless, general directives were established. In large outline, it was presumed that a respondent classified in the second-grade, i.e., mild, symptom formation must show evidence that he is effective at work, at home, and in social and interpersonal relations, even though he has such signs of psychosomatic distress as an "often" reply to one of the psychophysiological queries in the interview. Such a rating was consistent with mild anxiety or tension, if there was no evidence of paranoid thinking and the respondent was not grossly overweight or underweight.

A mental health rating "moderate" was consistent with substantial evidence of psychosomatic interference; with several "often" responses to the psychophysiological items; and with affirmative responses to "drinking too much" (R16–6), "eating too much" (R17–2), "restlessness" (R18–1), "poor memory" (R18–0), "not able to get going" (R19–5), and obesity, or malnutrition (W13, W14). Evidence of suspiciousness, rigidity, sustained low spirits, frequent worries, and moderate tension or anxiety were all consistent with a moderate rating. If there was evidence of interference by these symptoms in the respondent's life adjustment, this was indicated by a rating with the appropriate description: moderate symptom formation with some interference in life adjustment.

The estimate of the degree of interference in life adjustment was not easy to assess from Part I of the Summary form in which social adjustment and interpersonal factors had been omitted. Of course, agreement with such items as "pains in my back interfere with my work" or "high places, bridges, tunnels make me nervous" were self-implicating, but frequently the interferences had to be estimated from an evaluation of the total constellation of symptoms rather than from individual items alone. On a number of occasions the estimate of interference in life adjustment could be made only from revelations of social behavior contained in Part II of the Summary form.

Judgments of "serious symptom formation with some interference in life adjustment" or "with great interference in life adjustment" are essentially similar, except that the latter symptoms were of greater severity. The more severe rating was assigned to those respondents who could not sustain themselves by adequate employment or were otherwise unable to perform their assumed social function, such as that of mother or housewife. A rating of serious symptom formation was consistent with evidence of marked interference with bodily function, somatization, depression, paranoid thinking, rigidity, alcoholism, and a known psychiatric or court record indicating social maladjustment. Substantial falling off in occupational capacity, lack of satisfaction in living because of lack of friends, unusual loneliness, lack of recreational activities, and affirmative answers to several of the "worry" items as well as the observation by the interviewer of marked distress, contributed to a mental health rating of "serious symptom formation."

A judgment of "seriously incapacitated" was given to respondents with obvious evidence of psychotic illness or with evidence of inability to maintain employment and to function in any sphere, including family relationships. The mental condition of the respondents in this category was frequently comparable to that of patients hospitalized in mental institutions.

The main bases for the rating process were answers to the questions of the questionnaire-guided interview presented to the psychiatrist in the Summary form. Occasionally these questions were the only source of information, and the mental health rating had to be based solely on this document. However, most frequently, the respondents amplified their answers to the questionnaire items with comments which added further information, thus reinforcing the judgment derived from these items. Occasionally the comments were so revealing that the rating could have been made on the strength of these amplifications alone. The observations recorded by the interviewers also helped to clarify the rating.

Mental health Rating II was formulated after review and study of Part II of the respondent's Summary form pertaining to functioning in social realms. Objective information was also available on respondents with established social service files. A record of hospitalization, court appearance, social service assistance, or application to other welfare agencies added to the available information.

When the data on social functioning indicated a change of mental health rating, the considerations influencing the change were specified on the rating sheet. Thus, it was necessary for the psychiatrist to identify in his own mind what reasons induced him to change the rating, thereby clarifying elements of social functioning which contributed to mental health Rating II.

The psychiatrists graded with greatest confidence at the two extremes of the rating scale. They were more at ease and certain if the respondent gave no evidence of symptoms, in which case a Well mental health rating was readily ascribed. At the other extreme of the scale, definite psychotic symptoms, apparent either from answers to the questionnaire items, from comments of the respondent himself, or from the observations of the interviewer, were easily assessed as evidence of severe disturbance and functional incapacitation. But the grades of mental health in between these extremes were more difficult in that they left considerable latitude to the judgment of the psychiatrist and to his estimate of the degree of mildness or moderateness of symptom formation. At the intermediate points of the rating scheme, such values as intelligence, social achievement, relation to parents, personality characteristics, qualities pertaining to character disorder, and symptom clusters of a neurotic or borderline psychotic nature had to be weighed with deliberation; and the personal judgment of the rater was frequently strained to arrive at concise ratings from quantitatively imprecise symptoms.

The mental health rating of each respondent depended on the clarity with which the rater was able to reconstruct from the interview record a living personality on whom he could form a mental health judgment. While it might seem that the intermediary of a Summary protocol could fail to communicate the features of the respondent as a live human being, the corpus of data secured was of course specifically designed to facilitate the evaluation of the respondent's mental health status. The interview instrument was the product of months of selection of prestructured rating items which had previously undergone years of study of validation. Many of these items were known to have high correlation with psychopathology. Thus, when a protocol, complete with answers of the respondent, was presented to the psychiatrist, a substantial part of the rating was already embodied in the document either as agreement to the pathognomonic items or by their exclusion. The rater's task was to further coordinate and evaluate the partial judgments built into the questionnaire.

After the complete sample was rated by both evaluating psychiatrists, it was

finally necessary to reconcile on each respondent those series II ratings of the psychiatrists that were not in agreement. While several means of adjudicating these differences were considered, a formula was agreed upon as follows:

1. Where the series II ratings of the two psychiatrists were one level apart, the respondent was given the *healthier* rating. Thus, for example, respondents were finally rated Well not only when both psychiatrists agreed on this rating, but also when only *one* psychiatrist assigned this rating to the respondent. The other rating in such instances was invariably mild symptom formation. Thus the final Well category included some individuals with mental and emotional symptoms, but they were judged by one of the raters not to be of significance.
2. When the series II ratings of a respondent were two levels apart, the category intermediate was assigned to him.
3. When the ratings of the two psychiatrists were three levels apart, it was assumed that unusual problems of interpretation or comprehension of the record were involved and adjudication was accomplished by review of the respondent's record by a board of the three participating psychiatrists.

The derivation of the *final* mental health scale which represents the combined and adjudicated judgments of the two rating psychiatrists is presented in Table F-1. New designations for the final categories were created to replace

Table F-1. Key to Mental Health Categories

Independent* ordinal ratings	Definitions	Combined* ordinal ratings	Final category of symptom formation	
0	No significant symptom formation (symptom free)	0 1	Well	
1	Mild symptom formation, *but* functioning adequately	2 3	Mild	
2	Moderate symptom formation with *no* apparent interference in life adjustment	4 5	Moderate	
3	Moderate symptom formation with *some* interference in life adjustment	6 7	Marked	Impaired
4	Serious symptom formation, and functioning with *some* difficulty	8 9	Severe	
5	Serious symptom formation, and functioning with *great* difficulty	10 11	Incapacitated (partial or total)	
6	Seriously incapacitated, unable to function	12		

* Since the two raters independently assigned ordinal ratings from 0 to 6 to each respondent, the two independent ratings for each respondent were numerically joined to form combined ordinal values in a 0 to 12 range. One-step differences between the raters account for the odd numbered values in the combined ratings column. For example, if one judge rated a person 1 (Mild) and the other rated him 2 (Moderate), he received a combined rating of 3, placing him in the final category of Mild

the more cumbersome original definitions and also to arrange a serial gradation of severity of symptom formation by the use of one-word labels more easily referred to in the text.

The last three categories of the final symptom-formation scheme in Table F-1 contained respondents who were all considered as manifesting interference in life adjustment and difficulty in social functioning. Their symptoms were judged to be sufficiently severe to impair their social adjustment. Consequently in this volume they are frequently considered together as a group labeled Impaired.

In essence the final mental health scale used in this monograph is a summation of the independent judgments of the two rating psychiatrists. The basis for these psychiatric weightings were judgments of a variety of information derived from the interview report, which was designed to cover as large a range of psychopathology as was necessary to arrive at the desired classification. Incongruous qualities such as excitement, depression, overactivity, retardation, anxiety, phobias, paranoia, tension, and psychophysiologic symptoms had to be weighed and compared in order to arrive at ordinal values of the rating judgments. Thus it is not surprising that the psychiatrists were not always in complete agreement in their ratings. To provide the reader with a notion of the reliability of these judgments, we include here comparisons of the ratings of the psychiatrists expressed in terms of relevant statistical calculations.

The two psychiatrists who evaluated the mental health of all 1,660 respondents were in complete agreement on 47.2% of the cases. Setting aside one-step differences between the ratings of the two psychiatrists, the agreement increases to 86.7% of the sample. Mental health Rating I, derived from symptomatic data without knowledge of the factors of social functioning, showed a Pearson correlation of .75 between the two psychiatrists. Addition of social functioning data to formulate mental health Rating II slightly decreased the correlation between the two raters (.68). A subsample of 228 respondents was also evaluated by Rennie. These judgments were not used in the determination of the final mental health rating, but they provide a third independent set of evaluations for comparison with the other two judges. Examination of the intercorrelations of the three sets of ratings shows that a third psychiatrist's evaluations would have added little to the reliability of the final rating (Rennie II versus Michael II, $r = .77$; Rennie II versus Kirkpatrick II, $r = .61$; Kirkpatrick II versus Michael II, $r = .68$).

Contingency values, which are joint probabilities, based on the distributions of each psychiatrist's ratings indicate that the psychiatrists were in the greatest agreement at the extremes of the mental health continuum. The Well rating was given 4.3 times more often than would be predictable by pure chance. Ratings Mild (1.6 times chance), Moderate (1.8 times chance), and Moderate with some interference in life adjustment (1.8 times chance) offered the greatest challenge to the psychiatrists. Most disagreements were thus at levels where the criteria for symptoms lay in uncharted terrain of the subclinical level of symptomatology. As the severity of symptoms increased, so did the inter-judge agreements in classification. Thus, the category of serious symptom formation with some interference in life adjustment showed a concordance of 3.9 times chance. The category of serious symptom formation with great interference in life adjustment was agreed upon better than 9.5 times chance. The category of seriously incapacitated was reliable at 45.0 times chance. Extreme disability or freedom from significant symptoms was easiest to agree upon; mild or moderate symptom formation, most difficult.

The mental health ratings of the Midtown Study may be compared with

somewhat similar classifications made in other studies. The Pearson correlation between the two rating psychiatrists in the Midtown Study ($r = .68$) compares favorably with the correlation between paired ratings made by psychiatrists in a study of Marine Officer Candidates ($r = .15$).[3]

The average phi correlation between psychiatrists' ratings in the Midtown Study (.52) is similar to that obtained between psychiatrists in a study of 30 paratroopers (phi = .53).[4]

Identity of judgments between the two Midtown psychiatrists on 47.2% of the cases is clearly not ideal, but does approximate that achieved by psychiatrists directly observing 681 Navy servicemen, as reported by Hunt, Whitson, and Hunt.[5]

Obviously the ratings arrived at by psychiatrists, whether in this investigation or others, leave much to be desired in terms of scientific precision. Incompleteness, in clinical terms, of the record of information available to the judge, the difficulties of ordinal definition of personality characteristics or clinical symptoms, and diversity in value judgments derived from the personality differences of the raters cannot, combined at the conceptual level, achieve a mathematically predictable, consistent rating score. Yet for purposes of scientific investigation, comparisons must be made from respondent to respondent, and their mental health must be estimated in terms of ordinal symbols for elaboration by statistical means. Our aim was to make these ratings as objective as possible, considering that they are value judgments. It is our belief that reasonable approximation to objectivity was achieved, and we hope that the description and information here outlined will further understanding of the meaning of our mental health ratings.

To familiarize our readers further with the deliberations with which we approached the procedure of rating, we are appending four descriptions which would usually come under the heading of case material. This material was drawn by random selection from predetermined categories of the respondent mental health continuum. For our present purpose, the interview summaries of the selected respondents and the pertinent rating records (containing the individual judge's original ratings made approximately four years earlier), were returned to each psychiatrist independently along with instructions to reproduce his earlier rating procedure and to describe the considerations which led to the formulation of his mental health ratings. The independent descriptions obtained from the two rating psychiatrists were then given to an editor along with instructions to collate the two opinions into a flowing description of each individual case, with particular emphasis on preservation of the differences with which each judge approached the individual respondent. To protect individual identification, the collator of these profiles of each selected respondent was further instructed to omit sociocultural material which might identify the respondent. Indeed he was to frame substitute information, consistent with the sociocultural background of the individual case, but sufficiently different to prevent identification. The descriptions presented here are in essence vignettes of personalities reconstructed to demonstrate the approach of the two judges to the task of evaluating the mental health of each Midtown respondent. Preserved in these discussions is the psychiatrists' original usage of terms for the mental health categories rather than the abbreviated "Final" nomenclature used after adjudication of their independent evaluations of each sample respondent.

In the first vignette the records of the two rating psychiatrists are presented side by side. These are essentially verbatim reproductions of the records derived from the Summary form with omissions and reconstructions to prevent

identification. In the remaining vignettes the records of the two psychiatrists are fused into a running description with omission of repetitive material. Although these cases are not necessarily representative of the mental health category from which they were drawn, they are also not exceptional. Attention is particularly directed to the case rated in the category "no significant symptom formation." As may be seen, we had to overlook mild symptoms, especially if it were possible to counterbalance these by evidence of positive zest for living and constructive functioning.

PROFILE 1

Judge A

This respondent is a widowed female who married in her early twenties. She is now in her early fifties. She considers her health fair at present but better than it was four to five years ago. She thinks her appetite fair and sometimes has headaches and trouble with sleep. Her heart beats hard sometimes; she has had dizziness a few times and is sometimes nervous. She feels she eats too much, and every so often she feels hot all over. In childhood she had a little fear of animals, high places, and strangers and was much afraid of being laughed at. She liked school very much. She considers herself the worrying type and feels one should do everything perfectly, one should never show one's feelings to others, should be on guard with people, and keep opinions to oneself. She thinks one drink is one too many.

She feels she has not had her share of good luck, that nothing turns out right for her. In marriage the woman sacrifices, the unmarried can be just as content as the married, and most people do think a lot about sex. Personal worries get her down physically, and "you sometimes wonder if anything is worthwhile." High buildings, tunnels, bridges make her tense. She feels she doesn't always take good care of her health and often worries about the atom bomb. She reflects immaturity in agreeing that it is better to do things on the spur of the moment than plan ahead, that grief and sorrow are not for adults, and that there are no right or wrong but only easy and hard ways to make money. She was hospitalized for a prolapsed uterus. The interviewer observed that her attitude was suspicious and her interest mild, turning later in the interview to anger. She was nervous during the interview, her response was alert, her affect normal, and intelligence average. Her appearance was neat. The respondent was cautious but cooperative throughout. She had difficulty in deciding on the opinion and judgment questions. At the close of the interview she became extremely angry, flushed, and articulate. "Did [we] know how upsetting it is to remember things from many years ago? It is enough to make a person really sick. . . . How did [we] come to her?" She was mollified by the interviewer's discussion and explanation but still visibly shaken. Asked about any personal health rules, she answered, "I can't tell you, I just can't answer."

This respondent has psychophysiologic symptoms which are consistent with the menopause, which she had just passed or perhaps was still experiencing. However, her main difficulty seems to be an internal struggle dealing with moral problems. She manages to keep her hostility under control but seems to be neurotically subject to passive compliance which ends in resentment and outbursts of anger. Obviously this woman has problems which distress her intrapsychically. Nevertheless they do break into the open and in this respect probably interfere with her life adjustment. Her rigid personality and guarded,

hostile suspiciousness, and a dissatisfaction with her previous marriage and with her present state only compound her social adjustment. She was classified as moderate symptom-formation with some interference in life adjustment.

The background data indicate a generation I respondent of Czechoslovakian origin. Her husband died from a protracted illness several years after they were married. The respondent considers her mother the worrying type and feels she takes after her father. She states that there was never any discord between her parents and that her parents were always proud of their children. She felt her father spent too little time with her and her parents didn't practice what they preached. The respondent, her parents, and her spouse all had grade school level education. Her father worked on a small farm, and often had a hard time making ends meet. The mother worked full time. The parents had no occupational aspirations for the respondent, and her only aspiration was to work and support her parents. She is now working part time as a seamstress to earn money. She likes her work "fairly much" but feels upset by it. She visits two or three neighbors and has two or three close friends. Her leisure activities are mass media, reading, and the arts. Of her parents she says that they were "strict, and we did what we were told."

The social functioning data indicated no reason to change the mental health classification based on symptom items.

PROFILE 1

Judge B

The initial information of the Summary indicates this respondent to be a somewhat obese 50-year-old widow. She describes her present state of health as fair and says that this represents an improvement over several years ago. We know concretely about medical problems of serious order only that she had a genital operation about five years ago. However, she indicates to questions which can be called psychosomatic that she has considerable body concern, and reports some degree of distress to seven different questions, including eating too much and trouble with sleep "sometimes."

As to her childhood fears, little may be drawn from the four noted fears (of seven asked), except if one may infer much from the pair of responses, (1) fearing strangers "a little," and (2) "much" fear about being laughed at.

There follows a cluster of questions answered more or less deviantly. She calls herself the "worrying type"; she believes one should do everything perfectly, one should never show feelings to others; she believes in keeping her opinions to herself, in always being on guard with people, and that grief and sorrow are not for adults. This particular cluster of responses tends to reveal a somewhat compulsive, rigid, guarded person—perhaps a basically hostile and lonely person.

What more can we deduce? She indicates she has not had her share of good luck; that nothing ever turns out right for her; that she sometimes wonders if anything is worthwhile. This woman's underlying attitude is depressed and cynical. The rater skips to note the interviewer's observations and report: He describes her as initially friendly "with an undertone of caution. At the moment I indicated we had concluded, she became extremely angry, flushed, and articulate: 'Did [we] know how upsetting it is to remember things from many years ago? It is enough to make a person really sick. . . . How did [we] come to her? . . . People just spend their lives struggling to live and shouldn't be asked to relive. . . .' "

Here is revealed and affirmed the picture of a lonely, hostile, defensive, depressed woman struggling with considerable difficulty with the interview specifically and with life itself more generally.

The judge notes other evidence of pathology: She is made nervous by high places, for example. Also we read the interviewer's comment that she had great difficulty making up her mind on many opinion questions. But the picture seems fairly drawn at this juncture, i.e., that this is a seriously disturbed woman making some kind of crippled go of it. She was tentatively placed in the category of serious symptom formation with some difficulty in life functioning.

In the second part of the Summary it is noted that her husband died early in the marriage after a long illness. There is little more in the social functioning information to help us assess her mental health, except that she says she does visit with a few of her neighbors and has two or three close friends—suggesting she does maintain a level of socializing, perhaps adequate unto her personality. Of her avocations, she says she likes the mass media, reading, and the arts.

While this woman is functioning, perhaps with a certain stability, as indicated by her long go of it alone during and since her husband's illness and death, the rater's judgment remains that this is a seriously disturbed person functioning with some impairment.

After adjudication of the psychiatrists' difference in classifying this respondent, her final placement was in the Marked symptom-formation category within the Impaired range.

PROFILE 2

The respondent is a 50-year-old man of average build who has been married twice. He reports that he smokes and drinks too much. But his other responses have so little of the questionable in them as to make Judge B wonder whether this man has simply come up with what he believes are "correct" answers. We don't know what happened to his first marriage nor how much smoking and drinking he considers "too much." Although Judge B feels that this may be a "test miss"—that the man may have hidden disturbances—both rate him Well.

According to the interviewer, the man is friendly, alert, interested, intelligent, relaxed, and unanxious. He claims that his health is and has been excellent, although he has seen a heart specialist and a surgeon. He has been hospitalized for fractures and abdominal operations in the last five years; but he has forgotten his physician's name and has to check with his wife. He denies any evidence at all of psychosomatic complaints. Most of the time, he says, he is in high spirits.

He admits to having felt some childhood fears, but he did like school very much. He does not believe that one can be content unmarried or that women sacrifice more in marriage. He does feel that most people think a lot about sex. As personal health rules he states the desirability of moderation in eating and drinking and a reasonable amount of exercise—but remarks, "I don't always take good care of my health."

The social functioning data seem generally to confirm that this man is performing well. He had a happy home life as a child. Though he is not the research chemist he aspired to be, he is a satisfied and fairly successful public relations director in a related field (although his health is sometimes upset by his work). He spends much time in outdoor activities and is active in "social clubs." He says he has hundreds of friends. He attends religious services but says religion is not especially important to him.

Judge B does wonder whether the claim of excellent health is not now contradicted by the statement about his health being upset by his work. But neither this unusual response nor any of the other material available has clear enough significance to justify any rating but Well.

PROFILE 3

This bachelor of 30 strikes both judges as moderately disturbed. For some years now he has been troubled by high blood pressure and by a stomach ulcer, with cramps after eating and some regurgitation of blood. Although it is unusual for these conditions to occur together, and although essential hypertension is especially rare in so young a man, we find confirming evidence in his attitude projections.

Reasonably enough, he considers his present health as only fair; he adds that he suffers sometimes from damp hands, dizziness, and nervousness. He feels he both smokes and drinks too much—failures in self-control serious for a man with his physical ailments. He has difficulty relaxing after tense situations and getting to sleep. He does take some care of himself, for he lists his personal health rules as "Work, keep regular hours, get enough rest, and don't rush too much."

He recalls much childhood fear of being bawled out, some fear of spooky movies, and fear of one particular dog. He liked school. He is, he says, the worrying type, and some rigidity is reflected in what he would advise others: that one drink is too many, that one should avoid changing one's mind, that one should keep one's opinion to oneself. He considers himself a gambler at heart.

A whole cluster of responses suggest a man who is hostile, defensive, withdrawn, and unhappy: People are against him; he feels apart even among friends and a stranger even to himself; it is better to keep away from one's family; he has not had his share of luck. He does not feel that the single, such as himself, can be so content as the married.

We find in this man's suspicion and withdrawal enough evidence to grade him tentatively as moderate symptom formation with some interference in life adjustment. Judge B considers a sicker rating as perhaps appropriate, but then reflects that the personal health rules show some appropriate adjustment to physical conditions.

The social functioning data, though reflecting and in part explaining his disturbance, show this Midtowner as indeed no more than moderately disturbed. In his childhood he knew family pressures: a dominant, worrying mother ambitious for her sons; a truck-driving father proud of them but unable to give them much time; financial problems; family disagreements over religion, money, girls, school, and the boys' rights to make their own decisions. He has suffered various frustrations since: he did not, as he had hoped, go to college; his vague ambition to be a photographer never materialized; he does not even follow the related trade he learned, darkroom development. He likes his work in a warehouse; he earns less than $300 a month and feels his health suffers from the noise of machines there.

He has shown signs of other kinds of adjustments. He had functioned sufficiently in the Army to go through basic Army training and duty in the tropics. He seems not overly concerned about his physical ailments, for he comments only that his stomach cramps began when he was discharged and that he has "been told" about the high blood pressure. He rarely consults physicians be-

cause he is "never sick enough—what I don't know won't hurt me." He has four or five close friends and likes social dancing and spectator sports, although he remarks, "Big crowds would make me dizzy."

The judges remained persuaded of this man's neurotic symptoms, as evidenced in his interpersonal and social relationships. He is either a psychosomatic type suffering from symptoms of a mixed psychoneurosis or a personality trait type. In any event, they feel confirmed in their earlier rating.

This respondent was given final allocation to the Marked category of symptom formation within the Impaired range.

PROFILE 4

A male middle-aged Midtowner, married, strikes Judge B by his apparent misgivings about his capacities and reputation. He is often nervous, he says; his memory is "not all right"; he can't get going for days, weeks, even months. He feels people are against him; he worries about having no friends and about old age, and says that people talk about him behind his back—adding the typical defensive statement that he doesn't care what they think of him. When he first went to school, he volunteers, one teacher thought he might be retarded. "One should do everything perfectly," he says, and feels that "life does not give a lot of pleasure."

This respondent says his health is good—then notes three physical conditions which have recently required treatment, along with half a dozen presumably psychosomatic symptoms which afflict him sometimes or often. He hints at a nervous breakdown but resists the interviewer's questions about it. He seems hostile at the start of the interview and a little suspicious throughout, but offers repetitious answers, comments, and advice. Careful scrutiny of Summary Part I, without social functioning data, confirms the judge's impression of a seriously disturbed person: rating 4, serious symptom formation with some difficulty in functioning.

In Part II Judge B confirms the rating; for while he observes further and serious symptom formation, he sees this Midtowner functioning—with some difficulty to be sure, but still better than indicated by his own self-estimate. His antagonisms bespeak his disturbance. He is "opposed to religious programs" and their leaders—a "bunch of demagogues." (His wife's religion, it may be noted, is other than his own.) He expresses hostility toward both Old Americans and the European nation from which his father came. Wives' infidelity is "the worst thing in the world."

Yet he completed high school (his father had no schooling); he manages his own hardware store, likes the work (though he frets about overwork), and has an income in the sample's upper economic third. He has no children and lives alone with his wife; there is no specific indication of trouble between them. Largely because of his achievement in business he can be rated no worse than 4.

Judge A arrives at the same rating by only slightly different reasoning. Along with the psychosomatic symptoms, the depression and suspicion, and such signs of anxiety as defensiveness and rambling overtalkativeness, he finds a seeming disinterest and at the same time marked tension. Observing that this respondent claims good health, Judge A also finds significance in specific ailments (a long-time skin condition, arthritis, and bladder trouble for some ten years, some headaches and dizziness and trembling of hands, frequent nervousness and insomnia and cold sweats): childhood fears (of high places and of being

bawled out); and perhaps a sexual problem (he dated less often than others his age; he projects that most people think a lot about sex). Judge A notes the respondent's self-characterizing agreement that "you sometimes wonder if anything is worthwhile" and the interviewer's judgment that he is slow of intelligence but neat. The man's personal health rules especially strike this judge: "If one could feel content with his life and feel to the next person as to his brother man and always keep the next man his equal, he would live much longer and with a more natural life sexually"; "Don't indulge in degeneracy, especially homosexuality"; "From disease and drinking one can't keep a job, the mind gets warped, and one doesn't know the difference between right and wrong." Judge A considers the respondent as seriously disturbed and functioning with some difficulty.

Continuing into the social functioning data, Judge A is likewise impressed by the respondent's ability to run a business and to function in at least a limited family life. He notes, too, that he considers his religion very important and attends church, that he does have two or three close friends, and that he take rides into the country (he would prefer to live in a small town, "where life is more leisurely, clean, and healthful"). Judge A comments on some childhood background—disagreements with an "inadequate" father who had trouble making ends meet despite the "worrying" mother's full-time employment. Judge A is confirmed in his opinion that though this Midtowner shows near psychotic symptomatology, his ability to maintain himself in a business and to function in a limited family life gives him a mental health rating no worse than 4.

The respondent received a final classification of Severe symptom formation within the Impaired range.

FOOTNOTES

[1] A. Lewis, "Health as a Social Concept," *Brit. J. Sociol.*, vol. 4, p. 109, 1953; M. Brewster-Smith, "Optima of Mental Health," *J. Psychiat.*, vol. 13, p. 503, 1950; K. Menninger, *The Human Mind,* 1946; E. Fromm, *Escape from Freedom,* 1941; Lawrence S. Kubie, "The Fundamental Nature of the Distinction between Normality and Neurosis," *Psychoanalytic Quart.*, vol. 23, p. 167, 1954; Joseph W. Eaton, "The Assessment of Mental Health," *Am. J. Psychiat.*, vol. 108, p. 81, 1951; Shirley A. Star, "Popular Thinking in the Field of Mental Health," survey under auspices of National Opinion Research Center, University of Chicago, 1952; and Thomas A. C. Rennie and L. E. Woodward, *Mental Health in Modern Society,* 1948.

[2] T. A. C. Rennie, "Motivation in Health Education," in I. Galdston (ed.), *Psychological Dynamics of Health Education,* 1951, pp. 26–42.

[3] G. N. Raines and J. H. Rohrer, "The Operational Matrix of Psychiatric Practice," *Am. J. Psychiat.*, vol. 111, no. 10, pp. 721–733, April, 1955.

[4] H. Basowitz, S. Korchin, H. Persky, and R. Grinker, *Anxiety and Stress,* 1955, pp. 53–65.

[5] W. A. Hunt, C. L. Witson, and Edna B. Hunt, "A Theoretical and Practical Analysis of the Diagnostic Process," in Paul H. Hoch and Joseph Zubin, *Current Problems in Psychiatric Diagnosis,* 1953.

APPENDIX G *Characteristics of Midtown Compared with Other Populations (Based on United States Census of 1950)*

I. Housing

A. Substandard dwellings: proportion to total households in each population

1. Midtown 18.7%
2. Manhattan white* 18.5%
3. Queens 6.0%

B. Buildings with five or more dwellings: proportion relative to total residential buildings in each area

1. Midtown 95.0%
2. Manhattan 94.6%
3. Queens 32.5%
4. U.S. cities (pop. 100,000 and over) .. 13.3%

C. Owner-occupied dwellings: proportion relative to total dwellings of each population

1. Midtown 3.3%
2. Manhattan white 2.2%
3. Queens 42.1%
4. U.S. standard metropolitan areas .. 51.0%

D. One-occupant households: proportion relative to total households of each population

1. Midtown 24.8%
2. Manhattan white 20.8%
3. Queens 6.5%
4. U.S. urban 11.1%

II. Age

A. Children under age 15: proportion relative to each total population

1. Midtown 15.3%
2. Manhattan white 15.7%
3. Queens 22.0%
4. U.S. urban 27.7%

B. Adults over age 65: proportion relative to each total population

1. Midtown 10.6%
2. Manhattan white 10.0%
3. Queens 7.2%
4. U.S. urban 7.8%

III Sex

A. Ratio of females per 100 males in each population

1. Midtown..... 125
2. Manhattan white..... 108
3. Queens..... 107
4. U.S. urban..... 107

B. Employed females as proportion of total labor force in each population

1. Midtown..... 42.5%
2. Manhattan white..... 37.0%
3. Queens..... 30.3%
4. U.S. white (in nonagricultural work) 31.6%

IV. Marital status: proportion unmarried relative to total population over age 14 in each area

1. Midtown..... 31.7%
2. Manhattan white..... 29.7%
3. Queens..... 23.8%
4. U.S. urban..... 22.7%

V. Immigrants (including Puerto Ricans): proportion relative to total population in each area

1. Midtown..... 34.6%
2. Manhattan white..... 38.6%
3. Queens..... 19.7%
4. U.S. urban white..... 10.0%

VI. Reported education distribution of population age 25 and over in each area

Schooling	1. Midtown	2. Manhattan white	3. Queens
Elementary	47.8%	45.1%	44.9%
High school	32.8	34.1	41.7
College	19.4	20.8	13.4
Total	100.0	100.0	100.0

VII. Occupation distribution of employed population in each area

Occupation level	1. Midtown	2. Manhattan white	3. Queens
Professional and technical	15.3%	15.8%	10.8%
Managers and proprietors	11.0	13.0	11.9
Clerical and sales	22.0	25.4	30.0
Crafts and foremen	9.8	7.9	15.7
Operators	13.6	16.6	16.9
Household, other services	24.0	16.6	10.0
Laborers	3.2	3.3	3.4
Not reported	1.1	1.4	1.3
Total	100.0	100.0	100.0

VIII. Income distribution of families and unrelated individuals in each area

Annual income	1. Midtown	2. Manhattan white	3. Queens
Under $2,000	33.6%	32.7%	30.6%
$2,000– 2,999	18.7	17.7	16.6
$3,000– 3,999	13.7	13.0	17.7
$4,000– 4,999	7.5	7.2	10.8
$5,000– 6,999	7.5	8.5	10.7
$7,000– 9,999	3.2	4.3	4.1
$10,000 and over	7.9	5.8	2.5
Not reported	7.9	10.8	7.0
Total	100.0	100.0	100.0

* The United States census publications report marital status, schooling, occupation, and income for Manhattan nonwhites, overwhelmingly Negroes, by census tract units. Subtraction of the total nonwhite distributions from the total Manhattan distributions readily gave results relating to the Manhattan white population.

For housing and certain demographic characteristics not so reported, we had to proceed in a more roundabout fashion. We identified 39 census tracts that were almost solidly (95%+) Negro, in which lived three-fourths of Manhattan's nonwhite population. From the known demographic distributions of this 75% segment, we estimated the counts for the entire nonwhite population. Subtraction of these figures, as before, from total Manhattan data gave us by derivation estimated distributions for Manhattan's white population.

We may be challenged on the procedure of estimating the demographic characteristics of the 25% of nonwhites outside the 39 census tracts mentioned from the 75% in those tracts, on the ground that those living in mixed areas may be demographically different from those in solidly Negro areas. Actually, census tracts are arbitrarily drawn areas, each with 1 to 30 city blocks. Therefore, racially mixed tracts often have blocks that are solidly white, others that are solidly Negro, and still others that are indeed mixed. We estimate that of all nonwhites, less than 10% in 1950 were in mixed blocks. If these should be appreciably different in their demographic characteristics from those in solidly Negro blocks, which in the absence of evidence remains an open question, they are in any case numerically too few to affect to any significant degree the estimates we have derived from the solidly (95%+) nonwhite census tracts.

APPENDIX H *Errors, Artifacts, and Biases in the Mental Health Distributions among SES-Origin Groups*

Four potential sources of error in the research process may conceivably have contributed to the Well and Impaired trends reported in Table 12-1.

The first theoretical possibility that might make these trends spurious would be a sample unrepresentative of its population universe in socioeconomic composition.

Taking education as the only intersample index of socioeconomic status, we have seen in Appendix D that the respondent sample is almost identical (1) with our *complete* Home Survey sample and (2) with the Census Bureau's 20% sample of the relevant Midtown population universe as adjusted for the area's known changes between 1950 and 1954. On such double-barreled evidence, the specific possibility in question can be dismissed as remote.

The second potential source of error could intrude from the interviewers if, for example, they performed their inquiring role in such fashion that the information secured tended to make upper SES-origin respondents look better in mental health than they actually were, and lower SES-origin people worse than they were. We can adduce no direct evidence offering a guarantee that this kind of systematic bias was absent.

However, given that we had fully anticipated this possibility we can outline the steps we took to control and minimize it. It will be remembered that our interviewers were all professionals highly experienced in the interviewing art and thus aware of its fallibility.

Moreover, in their own social class origins (or SES group served in a professional capacity), the interviewers were chosen to cover almost the entire status spectrum. Thus, so far as it was practicably possible, it was our policy to assign each interviewer to respondents of the SES range and ethnic background closest to his family or professional experience. It is our opinion, based on our supervision of the interviewers, that the special leaning they harbored was a rather consistent one, combining both empathy for and clinical objectivity toward the respondent.

Hardly serving to dilute this predilection was their knowledge that according to a blueprint of our research design we intended to reinterview a subsample of our respondent population. Although the blueprint did not finally work out in the form originally anticipated, it was forseen by the interviewers as affording a technical opportunity to check the respondent information they were reporting.

On several grounds, therefore, it seems unlikely that our carefully selected and specially trained staff of professional interviewers had, wittingly or unwittingly, systematically or significantly, distorted the essential facts the case about their respondents.

Another potential source of bias in the data may be sought among the respondents themselves. That is, to explain the SES connection uncovered (Table 12-1) in these terms, it would have to be assumed that high SES-origin respondents tended to censor their answers to the symptom questions, whereas the lower SES-origin respondents in turn were more truthful in replying to these queries.

However, two considerations argue against this assumption. The first is the general observation that denial of symptoms, somatic as well as mental, tends to be a conspicuous mechanism among individuals of lower-class background; whereas people of higher-class rearing are able in a professional setting to confront and report their symptoms more readily and fully. Indeed, Hollingshead and Redlich[1] have observed that "denial or partial denial of psychic pain appears to be a defense mechanism that is linked to low status."

Second, we have reason to believe that several aspects of the Midtown Study's own public image—i.e., its sponsorship by a nationally known medical college and its "community health" focus—carried greater weight with higher SES-origin people than with lower-status respondents. Thus we sensed that the former, more often than the latter, accepted the interview in terms of its medical framework and conscientiously gave candid replies to its questions as a matter of both personal and civic responsibility. These orientations also become manifest when we examine the interview protocols. There it is quickly apparent that compared to their lower-status fellow respondents the sample's higher-SES people more often volunteered or elaborated revealing sensitive material about themselves.

The possibility we posed for evaluation here is that higher-SES people on the whole underreported their symptoms to a greater extent than did their lower-status fellows. The two considerations just presented suggest, on the contrary, that *lower*-SES respondents on the whole underreported their symptoms to a larger degree than did their upper-status neighbors.

In this light, if sample respondents as a source of error have skewed the SES-origin trend reported in Table 12-1, they may well have done so by understating the frequency of mental morbidity *not* at the top of the SES-origin range but at the *bottom*. If so, the association between parental SES and respondent mental health is larger (not smaller) than the Table 12-1 bears witness.

A fourth possible source of SES bias must be considered, one emanating from the Study's evaluating psychiatrists who judgmentally classified all sample respondents on a gradient scale of symptom formation. To measure the effect of this and related kinds of sociocultural bias, a two-stage mode of rating respondent mental health was devised for the psychiatrists. In formulating Rating I for each respondent, the psychiatrists had all symptom information except data about his functioning in sociocultural settings that might demographically identify him. In deciding Rating II, the psychiatrists additionally had the information so excepted and all other demographic data about the respondent, including those revolving around his socioeconomic status. Thus, if the sample's Rating II distributions, when compared with the sample's Rating I distributions, showed that the Rating II changes in certain SES-origin groups tended to be more favorable than those in other status groups, the presumption would have to be credited that the socioeconomic information had perhaps

contaminated the psychiatrists' judgments. Actual comparison of the "before SES knowledge" ratings (I) and the "after SES knowledge" ratings (II) reveals no status differentials in the direction of the rating changes made by the psychiatrists. We can accordingly infer that the trends in the SES-origin distributions observed in Table 12-1 are not to a perceptible degree an artifact of bias on the part of the Midtown psychiatrists.

Of the four potential sources of bias in the SES-origin mental health trends, evidence has been presented that two left no discernible traces of intervention. For two other possible sources of such error evidence is not available. For one of these sources of error, namely, the interviewing staff, the possibility was likely reduced by measures of control that appear to have been more or less effective. As to the respondents themselves as a source of error, there are reasons to believe that their differentially incomplete reporting of symptoms may have operated in a direction of *understating* the SES-origin differences recorded in Table 12-1.

All told, therefore, the chances seem large that the association there observed between parental SES and adult mental health is genuine, rather than a spurious result of errors and biases unlocked by the measurement process itself. Confirming findings from other investigations, presented elsewhere in this volume, seem to further enlarge these chances.

FOOTNOTES

[1] A. B. Hollingshead and F. C. Redlich, *Social Class and Mental Illness*, 1958, p. 176.

Index

Accidents, nonvehicular rates, 112–113
Acculturation of immigrants and descendants, 254–255
Adelson, J., 223, 228, 229, 239
Adler, L. M., 188, 350, 369
Adler, Polly, 104
Age factor, in Army study, 221, 346
  in Bellin-Hardt study, 183
  biogenic elements, 162–164, 330–332
  in contemporary America and classical China, 165–166
  and demographic factors, 162–163
  distribution in Midtown population and respondent sample, 36
  hospital patients, 160–161
  incapacitated respondents, 160–161
  generation-in-U.S., 162, 257–258, 276
  as independent variable, 18, 158, 339, 346
  mental health distribution, 159–168, 346
  military age groups, 161–162, 221, 346
  morbidity hypothesis, 162–163, 330–331
  parental role changes, 164–167, 170, 218–222
  in patient history, 167–169
  rates of clinic patients, 158–159
  rates of hospital patients, 158–159
  socioeconomic status, parental, 218–222, 356
  somatic disorders, 163–164, 332–333
  summarizing propositions on, 166–167
  Treatment Census, 167, 171
Aged population, Bellin-Hardt study on, 183–185, 346
  in Midtown, 81
  (*See also* Age factor)
Alcoholism, in Jewish population, 306, 319
  mortality, New York City, 112–113
  patients, New Haven study, 301–302
Alexander, Franz, 13, 23
Anastasi, A., 24
Anomia, 119, 199–200
Anonymity, metropolitan, 117–120
Anthropologists in research, 12, 190, 337
Army's Neuropsychiatric Screening Adjunct (NSA), 42–43, 139–140, 221, 346
Arrow, K., 25
Aspirations and socioeconomic mobility, 224–225
Assessment method, Rating I and Rating II, 50–52, 63–66, 161, 395–402
Atkinson, Brooks, 121
Atkinson, Oriana, 103
Attachment-detachment rates of ethnic groups, 286–289
Austrian group, attachment-detachment rates, 287, 288
  mental health, 290–291, 293
  number in generation I, 282

Bailey, Margaret, 30
Bales, R. F., 370
Baltimore study, 7, 188
  methods, 141–143
  prevalence rate, 141, 143
  sex rates, 174
  socioeconomic rates, 211–212
Barclay, Dorothy, 103
Basowitz, H., 57, 407
Bauer, R. A., 208
Beard, Charles, 190
Beard, Mary, 190
Beebe, G. W., 143, 155
Beers, Clifford, 4
Belknap, I., 172
Bellin, S. S., 189, 208, 238
Bellin-Hardt study, on aged population, 183–185, 221
  research design, 346
  sex morbidity rates, 179–180, 346
  socioeconomic morbidity rates, 221–222
Bendix, R., 222–223, 239
Benedict, R., 172
Berger, Meyer, 87, 102, 123, 124
Bernard, W. S., 280, 299
Berthoff, R. T., 298
Biogenic elements in mental health, age factor, 330–332

Biogenic elements in mental health, socioeconomic status, 328–329
Biosocial demographic variables, 20, 31, 339
Bloch, Jean, 209
Blue-collar workers, aspirations, 98
  cultural revolution and, 363–364
  immigrants to U.S., 260
  in-migrants to Midtown, 78
  mental health, 232–233
  in National Health Survey, 211
  occupational mobility, 227–228
  organizations, 109, 359
  socioeconomic status, 193, 197–198, 202
Boll, E. S., 197, 208
Booth, Charles, 190
Bossard, J. H. S., 197, 208
Boston Selective Service study, morbidity rate, 141, 144–145, 343
  rates of ethnic groups, 289
  socioeconomic rates (1942), 211–212
Bowers, R. V., 135, 154, 350, 369
Branch, C. H., 25, 155, 369
Brandeis, Louis, 366
Bremner, R. H., 370
Breslow, L., 207
Brewster-Smith, M., 407
Bridgman, P. W., 340, 341, 368
Brill, A. B., 303
Brill, Henry, 54, 143, 151
Brill, N. Q., 155
Brim, O. G., 370
British group, attachment-detachment rate, 287, 288
  mental health, 290–291, 293
  number in generation I, 282
Broken homes and socioeconomic status, 196
Brooks, J., 84
Bross, I. J., 24, 375
Broun, Heywood, 120, 124
Brudner, E. E., 312, 324
Buell, Bradley, 5

Calabresi, M., 299
California Health Survey, 156
Campisi, P. J., 279
Cannell, C. F., 56
Cantril, H., 189
Caplow, T., 57
Capote, Truman, 95, 102
Carnegie, Andrew, 222
Catholic group, hospital and clinic rates, 302–303
  mental health composition, 304–307, 347
  New Haven study, 301–303
Catholic group, parental religiosity, 304, 307–313
  patient-history variable, 315–320
  professional orientation, 316–319
  religious mobility, 313–315
Chevry, G., 387
Chicago as metropolis, 70, 71, 81
Child, I. L., 279
Children, clinic facilities for, 132
  in Midtown population, 80–81, 88
  New York City as place to grow up, 99
  parental religiosity, 307–313
  parents' mental health, 165–167, 170
  patients, psychiatric, 158–159
  rural-urban upbringing, 267–268
  sleep and play space for, 94–97
  social agencies for, 111–112
  socioeconomic status consequences for, 194–200, 215–216, 234, 355–356
Chisholm, R. M., 289, 299
Church, attendance in Midtown, 108
  Catholic, and psychoanalysis, 320
  and professional orientation, 318, 320
Clark, R. E., 251
Class, social, discrimination and racial lines, 360–361
  mental illness types preferred, 217
Class system, social, closed and open types, 193
Classification, mental health (*see* Mental health)
Clausen, J. A., 20, 23, 25, 56, 134, 153, 154, 208, 251, 281, 368, 382
Cleveland, E. J., 199, 208
Clinic patients, age rates, 158–159
  generation-in-U.S. rates, 273–274
  marital status rates, 187–188
  prevalence, Midtown and New Haven, 129, 351–352
  religious group rates, 302
  services received, 129
  sex rates, 174
  socioeconomic rates, Midtown, 241
    New Haven, 243
Clinics, chance of acceptance, 132
  for children, 132
  number, in Manhattan, 131
    in New Haven, 131
Cochran, W. G., 25, 55
Cohan, George M., 100
Cole, N. J., 155
Coleman, M. D., 164, 172
College population, prevalence of emotional problems, 220–221, 346
Collins, S. D., 172, 335
Commission on Chronic Illness, investigation, 141
Committee on Research in Psychiatry and Social Sciences, SSRC, 12

Committee on Social Issues, Group for the Advancement of Psychiatry, 12
Communicable disease death rates (1900, 1953), 371
Community, family functions and, 13
  further investigations needed, 364–366
  institutions in, 104–105, 107
  Midtown area as, 105–110
  morbidity rates, comparability, 145
  national mental health and, 14
  psychiatrists' participation in, 3–7
  rural-urban differences, 13–14
  sociographic study of, 28–29
  studies, comparability of, 343–346
Community Council of Greater New York, 114, 123, 153, 370
Component variables, 20–21, 321, 354
Connolly, Cyril, 102
Cooper, James Fenimore, 84
Cooper, M., 5
Cornell Medical College, 44, 54–55
Cottrell, L. S., Jr., 172, 370
Cowden, R. C., 57
Cowley, Abraham, 102
Criteria of sound mental health, Rennie's, 62, 395
Cultural differences and nationality factor, 283–284
Cultural revolution, gains and side effects of, 362
Czechoslovak group, attachment-detachment rates, 287, 288
  mental health, 290–291, 293
  number in generation I, 282

Darwin, Charles, 101–102
Davis, Allison, 207
Davis, C. B., 371
Dawber, T. R., 24, 55, 371, 382
Dean, S. E., 58
Delinquency, juvenile (*see* Juvenile delinquency)
Democratic practices and mental health, 360–361
Demographic variables, biosocial type, 17, 20
  define community groups, 17, 157–158
  Ethnic Family operation, 284
  independent, 15–20, 304, 339–340, 344–349, 354–358
    limitations, 344–345
  interlocking, 340
  reciprocal, 17–20, 175–176, 200–201, 225, 304
  sociocultural type and family constellations, 19–20, 339
Dependent variable (adult mental health), 15, 17, 304
Determinism, environmental, 16
de Tocqueville, Alexis, 190
Di Donato, Pietro, 280
Diethelm, Oskar, 12, 337
Disease, somatic, causation, 14–15
    patterns of, 15–16
    research strategy, 9
    (*See also* Somatic disorders)
Divorce status and mental health, 185–186
Dollard, John, 54, 111
Doull, J. A., 11
Douvan, E., 223, 228, 229, 239
Downes, Jean, 7
Downing, J., 25
Drift theory defined, 280
Dunham, H. W., 23, 251, 281
Dysfunctions, American socioeconomic system, 249
  sociocultural, historical trends, 359–362

Eaton, Joseph W., 407
Edman, Irwin, 120, 124
Education, composition, in Midtown, 385, 409
  factor in Army study, 221
  as indicator of socioeconomic status, 201–204
  about mental health, 4–5
  for parenthood, 361–362
Eells, K., 208
Eliot, T. D., 23
Ellis, J. M., 207
Epidemiology, medical (*see* Medical epidemiology)
Escalona, S., 367–368
Ethnic Family operation, 284
Ethnic groups, age composition, 285
  attachment-detachment rates, 285–289
  cultural congruity and differences, 283–284, 287–289
  educational composition, 284–285
  generation-in-U.S. composition, 284
  hypotheses on, 288–289, 297
  intergeneration differences in mental health, 293–295
  intermixing, 284–285
  mental health distributions, 289–295
  mortality differences, 289
  organizational participation, 109
  patient-history factor, 295–296
  population changes, 283
  rejection rates of, in Boston study, 289
  religious composition, 284, 285
  rural-urban origins, 285
  second and third generations, 79–80, 282–283
  socioeconomic status, 80, 285, 292, 295

Ethnic groups, stereotyping of, 284, 285
types N and O, 261–266, 292, 356–357
Ever-patients among Impaired respondents, age groups, 168, 296
defining criteria, 146, 246, 275
ethnic groups, 296
generation-in-U.S. groups, 275–276
religious groups, 315–316
severity of impairment classes, 147
socioeconomic groups, 246
Ewalt, Jack R., 23
Ex-patients among Impaired respondents, age groups, 168, 296
defining criteria, 146, 246, 275
generation-in-U.S. groups, 275–276
religious groups, 315–316
severity of impairment classes, 147
socioeconomic groups, 246
effects of psychiatric attention, 248–249

Family, assessment of, 19–22
as basic unit, 13
children in, 194–200, 356
cohesion and socioeconomic status, 197, 355–356
and community differences, 13
demographic alignments, 19–20, 339
farming, in U.S., 70
fertility of, in Midtown, 80–81, 88
function and malfunction, 354–356, 358–359
income, 355–356, 359
investigations needed on, 365–366
in Jewish group, 303, 306, 319–320
sociocultural factor, 355, 358–359
in socioeconomic groups, 192
Faris, R. E. L., 251, 280
Farnsworth, D. L., 238
Father-mother relationship, and children, 196, 200
in family functioning, 355–356
Fein, R., 22
Feldt, A., 55
Felix, R. H., 22–23, 135, 154, 350, 351, 369
Female role, married, 177–178
unmarried, 179–183
Fichter, J. H., 323
Firey, W., 86
Foote, N. N., 370
Foreign-born group (*see* Generation I)
Form, W. H., 207
Fortune magazine, 300, 322
Francis, Thomas, 23
Frank, Jerome D., 54
Freud, Sigmund, 12, 320, 366–367
Friedsam, H. J., 172
Fromm, E., 12, 407
Frumkin, R. M., 251, 369
Funkenstein, Daniel, 312, 324

Galbraith, J. K., 370
Galdston, I., 154, 407
Gardner, B. B., and M. R., 207
Generation I, attachment-detachment rate, 286–289
average age, 279
defined, 253–254
hypotheses on, 256–261
mental health distribution, 257–258
patients, hospitalized in New York State, 272
total in Midtown, 273–274
total in New Haven, 272–273
population, decrease of, 283
predicament of, 254–255
representation of, in ethnic groups, 284
types O and N, 261–266, 348, 356–357
Generation II, attachment-detachment rate, 286–289
average age, 279
defined, 253–254, 279
hypotheses on, 256–261
in-migrants vs. native New Yorkers, 79, 265
mental health distribution, 257–258, 265–268
patients, total in Midtown, 273–274
population, decrease of, 283
predicament of, 255
Generation III, attachment-detachment rate, 286–289
average age, 279
defined, 253–254, 279
hypotheses on, 256–261
in-migrants vs. native New Yorkers, 79, 265
mental health distribution, 257–258, 265–268
patients, total in Midtown, 273–274
population, increase of, 283
representation of, in ethnic groups, 284
Generation IV, average age, 279
defined, 253–254
in-migrants vs. native New Yorkers, 79, 265
mental health distribution, 257–258, 265–268
patients, total in Midtown, 274
population, increase of, 283
Generation-in-U.S. groups, average age, 279
classification criteria, 253, 279

Generation-in-U.S. groups, distribution in Midtown samples, 253, 384
help need and patient history, 274–276
professional orientation, 276–277
hypotheses on, 254–256, 258–261, 357
independent variable, 18, 339, 347–349
in-migration and, 265–268
Malzberg-Lee study, 271–273
mental health distributions, 257–258, 347–349
Odegaard's study, 270–271
parental socioeconomic status, 257–258, 261–265, 268
patient-history variable, 274–276
rural-urban origins, 261–268
Treatment Census findings, 268, 273–274
treatment rates, 272–273
(*See also* Generation I, etc.)
German group, attachment-detachment rate, 287, 288
mental health, 290–291, 293
number in generation I, 282
Ginsberg, E., 172
Ginsburg, S. W., 251
Gladwin, T., 57
Gold, David, 54
Goldhamer, H., 281, 363–364, 371
Goode, W. J., 196, 207
Gordon, J. E., 11, 24, 154, 368
Gordon, M. M., 206, 207
Gordon, Raymond L., 58
Gradients of symptom formation, 135–137, 341, 342
Granet, M., 172
Gregory, I., 196, 207
Gross typology classification system, 139
Group for the Advancement of Psychiatry, 12, 370
statistical standardization of groups, 279–280
Gruenberg, E. M., 12, 57, 134, 136–137, 153, 154, 335, 350, 351, 369
Gunther, John, 70

Haase, W., 58
Hailman, David E., 236
Hall, J. K., 23
Hammond, S. B., 208
Handlin, Oscar, 255, 279
Hansen, M. H., 55, 387
Hansen, Marcus, 256, 279
Hardt, R. H., 189, 238
Hauser, P. M., 55, 207
Havighurst, R. J., 208
Heider, G. M., 367–368
Help need and patient history, age groups, 167–168
defined, 145–146
generation-in-U.S. groups, 274–277
marital status, 186–188
and professional orientation, 276–277
psychiatrist's commentary on, 334–335
religious groups, 315–320
socioeconomic groups, 245, 247–251
Herzog, E., 324
Hicks, Granville, 102, 117–118, 121, 122, 123
Hoch, Paul H., 152, 154, 407
Hoguet, René, 209
Holiday magazine, 102
Hollingshead, A. B., 152, 153, 207–209, 237, 239, 241, 243, 251, 252, 369, 370, 382, 413
Holmes, Oliver Wendell, 75
Home Interview Survey, compared with other surveys, 139–145, 343
methods, 31–53, 60–66, 132–137, 337–342, 395–407
replications, 364–365
socioeconomic status measures, 201–204
Horney, K., 12
Hornick, E., 164, 172
Hospital Council of Greater New York, 106
Hospitals, general, 106
psychiatric, area, "law of distance," 281
kinds of treatment, 152
length of treatment, 128
New York State, overcrowding, 130
number serving Manhattan, 127–128
patient rates, age, 159
generation-in-U.S., 268–273
indicator of illness, 272, 274, 350
intercommunity differences, 130
married and unmarried, 186
Midtown, 128
religious group, 301–303
sex, 174
socioeconomic, Midtown, 240–241
New Haven, 243
permanent patients, 243
readmissions, 128
Housing, characteristics, Midtown, Manhattan, and Queens, 408–410
density, 72–74, 94–95
dwellings per building in five boroughs, 73
owner-occupied, 85
public projects, 94, 114
slums, 114, 338
social-class history, 74–77
and socioeconomic status, 191–192, 201

Hugo, Victor, 360
Hungarian group, attachment-detachment rate, 287–288
mental health, 290–295
number in generation I, 282
Hunt, W. A., 137, 407
Hyde, R. W., 141, 155, 236, 237, 289, 299
Hyman, H. H., 56, 207
Hypotheses on mental health, age groups, 162–163, 166
cultural revolution, 362–363
ethnic groups, 288–289, 297–298
family, malfunctioning, 358–359
generation-in-U.S., 254–256, 258–261, 357
independent demographic variable, 354–358
Jewish group, mental health, 305–307
marital status, 186
mobility aspirations, 224
in New Haven study, 351
parental religiosity, 307
professional orientation of religious groups, 318–319
socioeconomic status, 200, 206, 224–225, 329–330
sociogenic, 328–329

Immigrants, acculturation, 254–255
ancestral culture, 283–284, 288
attachment-detachment rate, 286–289
characteristics, before and after 1921, 260–261
economic origins, 79
hospitalization rates, New York State, 272
literature on, 254–255, 259
mental health distribution, 257–258
national origins, 78–80, 282
New Haven study, patients, 273
objective selection, 263–264, 280
as returnees to native lands, 280
role discontinuity, 255, 357–358
rural-urban origins, 79, 261–268
shrinkage, in Midtown, 283
subjective selection, 263–264, 280
time length in United States, 280
treatment rates, 271–273
types N and O, 261–265, 356–357
(*See also* Generation I; Generation-in-U.S. groups; Immigration)
Immigration, to American metropolis, 78
laws affecting, 260–261, 263, 348
to United States (1901–1914), 260–261
(*See also* Immigrants)
Impaired mental health category, 64, 342–343
help need, 145–146
occupational mobility, 224–229
patient-history distribution, 147–148
professional orientation, 147–148
symptom-formation classification, 64, 135–137, 342
treated and untreated, 334
unmet demand for therapy, 149–150
Incidence vs. prevalence rates of treatment, 30–31, 281, 380–382
Income, family, during 1900–1950, 359–360
in socioeconomic status, 191–192, 201, 230, 355–356
Independent demographic variables, 15–20, 304, 339–340
age factor, 158
further hypotheses, 354–358
limitations of, 344–345
religious origin, 18–19, 304
socioeconomic status, 201, 204, 214–215, 354–358
test findings, 345–349
Infant mortality rates, 112–114
Inkeles, A., 298
In-migrants, Midtown, 78, 86, 90
compared to native New Yorkers, 265–268
generation-in-U.S., 265–268, 348–349
Puerto Ricans as, 282, 293
sexual selection of, 181
social distance, 268
Social Science Research Council on, 269–271
subjective selection, 265, 268
urban-origin variable, 265–268
In-patients (*see* Hospitals, psychiatric)
Institutions, central, 110–116
community, 104–105, 107
types of, 105–110
Interdisciplinary research, difficulties of, 6, 9–10, 59
Interview operations, 36–38, 59, 60
assessment of, 46–48
content, 40–43
interviewer bias, 214–215, 411–413
interviewer observations, 40–42
objectives, 31–32
respondent interest in, 47–48
respondent orientation to, 44–45
Irish group, attachment-detachment rates, 287, 288
mental health, 290–291, 293–294
number in generation I, 282
professional orientation in New Haven study, 317–318

Irish group, rejection rates in Boston study, 289–290
Italian group, attachment-detachment rates, 287–288
mental health, 290–294
number in generation I, 282
rejection rates in Boston study, 289–290

Jaco, E. G., 207
Jaffe, A. J., 251
Jahoda, Marie, 24, 54, 56, 364, 368, 369, 371
Janis, I., 306, 323
Jewish group, causal interpretation, 303
hospital and clinic rates, 302–303
hypotheses on, 305–307
immigrants, national origin, 282
mental health composition, 304–306, 347
New Haven study, 301–303
parental religiosity, 309–310, 312
patient-history variable, 315–320
professional orientation, 316, 320
religious mobility, 313–315
Johnson, N. A., 151, 382
Joint Committee on Mental Health and Illness, 368
Judgmental bias in classification, 48–52, 63–64, 154, 214–215, 258–259, 411–413
Juvenile Aid Bureau, 111–112
Juvenile delinquency, 5–6
in Midtown, Manhattan, and New York City, 111–113, 115–116
rates, 111–114
research approach, 5–6

Kahn, R. L., 56
Kannell, W. B., 55
Kaplan, B., 251
Kapp, I., 206
Kaufman, R., 335
Kazin, Alfred, 86, 92, 102
Kety, S. S., 24
King, Alexander, 323
King, S. H., 312, 324
Kingsley, L. V., 141, 155, 236, 237
Kingsley, Sidney, 86
Kirk, Grayson, 102
Kirkpatrick, Price, 39, 40, 63, 135
Kish, L., 25
Kitt, A. S., 370
Klein, Alexander, 84–86, 102, 103, 124
Kluckhohn, C., 23, 207, 238
Kluckhohn, F. R., 207
Knupfer, G., 197–198, 208
Koenig, S., 279
Kohn, M. L., 251
Kornhauser, A., 55, 103
Kouwenhoven, J. A., 86
Kramer, Morton H., 22–23, 152, 172, 382
Kubie, Lawrence, 57, 407

Langner, Thomas S., 39, 55, 367
Lansing, J. B., 25
Lardner, John, 91, 92, 120, 124
Lawrenson, Helen, 124
Lawshe, C. H., 368
Lee, E. S., 269, 271–272, 281
Leighton, Alexander H., 23, 208, 336–337
LeMasters, E. E., 172
Lemkau, P., 5, 12, 53
Lerner, D., 23, 56
Lerner, Max, 85, 190, 193, 206, 207, 254, 259, 279, 280, 369
Levinson, D. J., 298
Lewin, K., 255, 279
Lewis, A., 407
Lewis, Oscar, 208
Life expectancy, 195–196, 362, 371
Linden, M. E., 172
Lindesmith, A. R., 298
Lindsey, G., 298
Lipset, S. M., 222–223, 239
Loeb, Martin, 208
Longaker, W. D., 199, 208
Louisville, Kentucky, study, 4–5
Lower classes, disorder preferences, Ruesch on, 217
handicaps of children of, 196–199
Luborsky, L., 154
Lunt, Paul S., 54, 206
Luton, Frank, 5, 7, 188
Lynd, Helen, 54, 190–191, 206
Lynd, Robert, 54, 190–191, 206
Lynes, Russell, 206
Lystad, M. H., 239

McCaffery, E., 25
Mack, R. W., 209
McNulty, John ,118, 123
Malamud, D. I., 368
Male role, married, 177–178
unmarried, 179–183
Malfunction and function, psychiatric concept of, 61–62
Malzberg, Benjamin, 153, 251, 269, 271–273, 281, 300–301, 322, 369
Manhattan, central business section, 71,
clinics, number, 131
as competitive society, 117
controversy on children living in, 94

Manhattan, economic and social history, 71, 74–76
housing, 76–77, 104
motives for settling in, 93–94
as place to live, 99–102
office therapists, number, 131
privacy in, 120
Puerto Rican population, 87
racial composition, 77–78
reduction of population (1910–1936), 261
religious composition, 87
sex ratio, 181–182
tempo, 117
working population, 71
Marceau, Felicien, 370
Marital status, as demographic variable, 18–19, 175–176, 339
divorced, impairment rates, 185
help need and patient history, 186–188
husbands and wives, impairment rates, 177–178
selection processes, 180–182
treatment rates, 186–187, 350
unmarried adults, impairment rates, 178–179
widows, impairment rates, 184
Marquand, John P., 86, 190
Marshall, A., 281, 363–364, 371
Mason, A. T., 371
Maxwell, Gavin, 262
Mayer, A. J., 207
Mead, Margaret, 172, 188, 371
Medical epidemiology, and community population, 133–134
demographic variables, 339–340
and ethnic factor, 289
historical development of, 10–11
role of, in Study, 10–11, 337
and social environment, 11
and socioeconomic status, 195
Melville, Herman, 89, 92
Menninger, Karl, 135, 153, 154, 407
Mental health, assessment, 40, 63–64
clinical patients, calibration, 136
criticism of, 136
gradient classifications, scale, 64, 133–135, 399–400
gross typology, 139
interjudge adjudication, 399
interjudge agreement, 400–401
judgmental bias, 48–50, 161–162, 178–179, 214–215, 258–259, 412–413
limitations, 340–341
psychiatrists' criteria, 64–66, 396–398
symptom formation data, 40–43
validation in Navy studies, 137
Merton, R. K., 153, 199, 208, 238, 368, 370
Methods of Home Interview Survey, 26–28
descriptive vs. statistical, 27–28
interviewing, 36–38
orientation of respondents, 44–45
precision degree, 27
questionnaire, 39–44
sample design and participation, 32–36
Meyer, Adolf, 12, 24
Michael, Stanley T., 40, 337, 369
Middle class, community organizations, 108–109
culture, Ruesch on, 217
family, cohesion in, 197–198
Middletown study, 190–191, 206
Midtown as community, community and public institutions, 105–110
business institutions, 105
central institutions, 114–116
churches, 107–108
class groups, 108–109
professional services, 105–107
religious denominations, 322
schools, 109–110
housing, accommodations for children, 94–95
characteristics compared with Manhattan and Queens, 408
density, 73–74
middle-class, 77
owner-occupied, 85
slums and public housing, 114
tenements, 76
upper-class enclaves, 76
population, characteristics compared with Manhattan and Queens, 338, 408–410
characteristics of settlers, 90
composition of, 77–81
density, 72–73
other "gold coast and slum" areas, 82–83
Puerto Ricans in, 87, 338
racial composition, 77–78
white-collar workers, 97–98
psychosocial climate, 116–122
complexity, 338–339
personal anonymity, 117–120
tempo, 117
Miles, Henry H. W., 24
Military age group, morbidity rates of, 144, 161–162
Miller, Arthur, 124
Miller, W. B., 197, 207, 208
Mills, C. Wright, 285, 298
Minneapolis–St. Paul study, 5
Minnesota Multiphasic Personality Inventory (MMPI), 42–43
Mobility, religious, 313–315

Mobility, socioeconomic status, 222–229
aspirations, 224–225
occupational, 226–229
social scientists on, 223–224
studies on, 222
Moore, F. E., Jr., 24, 54, 56
Morbidity, mental, accuracy in detecting, 43–44
age trends, hypotheses on, 166–167, 330–333
Army study, 144, 221–222
Baltimore study, 142, 342
Bellin-Hardt study, 179, 183–185, 221
Boston Selective Service study, 141, 144–145, 343
in college population, 220–221
and community, 3, 157
confusion about, 4–5
frequency in medical practice, 141–142
Midtown, inclusive, 138–140
Salt Lake City study, 141
Morgan, N. C., 151, 382
Morley, Christopher, 117
Mumford, L., 85
Murphy, Gardner, 172, 208, 367, 371
Murray, H. A., 238
Myers, Jerome K., 281, 317–318, 322, 324
Myerson, Abraham, 303

Nagle, B. F., 368
National Health Surveys, 58, 135, 154, 207, 211, 370, 382
National Institute of Mental Health, 9, 375
National origin, group attachments of, 285–289
Interview Survey and United States Census, 384
of immigrants in Midtown, 79
mental health distribution, 289–295
(*See also* Ethnic groups; Generation-in-U.S.)
National Selective Service Study, 211
Nationality attachment-detachment scale, 286
Negroes, community studies of, needed, 365
estimates from Census Bureau reports, 410
number in Midtown and Manhattan, 24, 77–78, 384
residential segregation, 77–78
social evaluation processes, 360–361
Neugarten, B. L., 198, 208
Neuropsychiatric Screening Adjunct (NSA), U.S. Army, 42–43, 139–140, 221, 346
Never-patients category, age group, 168
generation-in-U.S., 275–276
in impairment severity classes, 147
professional orientation, 148–149
religious origin, 315
socioeconomic status, 246
New Haven psychiatric patient study, clinic patient rates, 129
clinics, number, 131
generation-in-U.S. rates, 272–273
hypotheses and inferences, 351
nonpsychotic patients, 130
office patient rates, 129
office therapists, number, 131
psychotics, out-patient treatment, 130
religious groups, 301–303, 317–319
social class mobility and treatment rates, 222–223
social class in psychiatric operations, 369
social class rates, 240–244
state hospitals, overcrowding, 130
therapists' selection of patients, 353
New Orleans study, 222
New York City, carpetbaggers in, 93, 99
child care agencies, 111–113
coherence of, 300
economic opportunities in, 71, 89–90
exodus to suburbs from, 97
hospital costs, 106
juvenile delinquency, 111–113, 115–116
migrants to, 93
minimal income norm, 359
need to live in, 97–98
population, 70–73
residential buildings in, 73
robot communication, 119
social service agencies, 110–111
views on, 91–92, 100–102
(*See also* Manhattan)
New York City, Board of Education, 97
Bureau of Child Welfare, 132
Committee on Mental Hygiene of the State Charities Aid Association, 156
Community Mental Health Board, 156
Housing Authority, 94, 123
Planning Commission, 84
Welfare Department, 110–111, 234, 359, 360
Youth Board survey on children of needy families, 234
New York Herald Tribune, The, 86
New York State, Department of Mental Hygiene, 54–55, 151

New York State, Department of Social Welfare, 123
New York State mental hospitals, immigrant and native-born rates, 272
overcrowding, 130
New York Times, The, 87, 102, 115, 238, 359, 370, 371
New Yorker, The, 84, 85, 121
Norwegian immigrants in Minnesota, Odegaard's study on, 269–271
Nye, I., 196, 207

O'Brien, J. A., 324
Occupation, as indicator of socioeconomic status, 191–192, 201–202, 211–213, 230–239, 246
mobility, 225–229
Ochs, Adolph S., 54
Odegaard, Ornulv, 269–271, 281
Oeser, O. S., 208
Old Americans, in Midtown, 79–80
group identity, 254
rejection rates in Boston study, 289–290
(*See also* Generation IV: Generation-in-U.S. groups)
Oliver, H. K., 238
Opler, Marvin K., 284
Organic mental disorders, 61–62
Orlansky, Harold, 303, 323
Osler, William, 195
Out-patients, current among Impaired respondents, age groups, 168
defining criteria, 146, 246, 275
generation-in-U.S. groups, 275–276
religious groups, 315–316
severity of impairment classes, 147–148
socioeconomic groups, 246

Page, C. H., 206
Parent-child relationship, socioeconomic status and, 196–197, 200
Parental religiosity, and mental health, 307–313
parent distributions, 308–312
Catholic group, 311–312
Jewish group, 310–312
Protestant group, 310–312
social change, 313
Parenthood and mental morbidity, 164–165, 356–357
Park, Robert E., 91, 102, 124
Parsons, T., 172, 370
Pasamanick, B., 207, 251
Patient-history variable among help needy, age groups, 168
generation-in-U.S. groups, 275–276
Patient-history variable among help needy, national origins, 295–296
religious groups, 315–320
severity of impairment classes, 146–147
sex and marital status, 186
socioeconomic groups, 246–247, 249–250
Patients' prevalence rates (*see* Treatment Census)
Patno, M. E., 299
Payne, S. L., 56
Peck, R. F., 207
Perkins, Percival, 209
Personality structure investigations, need for, 365
Pfautz, H. W., 206
Physicians, number of, in Midtown and Manhattan, 105–106
Pope Pius II, 320
Population, aged, in Midtown, 81
composition, 77–78, 384
density of, in Manhattan, 72, 337
in-migrants, Midtown, 78, 88, 90
New York City, 70–73
Puerto Rican, 87
reduction in (1910–1930), 261
shrinkage of immigration (1910–1950), 283
Porges, Kurt, 209
Postpartum disturbances, 164–165
Prevalence vs. incidence rates of treatment, 30–31, 281, 380–382
Professional orientation factor, generation-in-U.S. groups, 276–277
Impaired never-patients, 148–149
religious groups, 313–320
socioeconomic groups, 247–248
and treatment seeking, 353
Professionals, number of, in Midtown and Manhattan, 105–106
Protestant group, hospital and clinic rates, 302–303
mental health composition, 304–307, 347
New Haven study, 301–303
parental religiosity, 307–313
patient-history variable, 315–320
professional orientation, 316–320
religious mobility, 313–315
Psychiatrists' offices, increase in, 131–132
number of, in Manhattan, 131–132
selective demographic exposure, 303
Psychiatry, classification in, 134–135
clinical, and community role, 3–4
concept of individual function and malfunction, 61–62
effects of care, 128, 130, 249–251
experience of, in Study, 60–61

Psychiatry, family assessment, 19–20
preventive, 4–6
statistics, view on, 24
(*See also* Social psychiatry)
Psychotic in-patients and out-patients, 130, 244
(*See also* Morbidity, mental)
Puerto Rican group, attachment-detachment rate, 287–288
community studies of, needed, 365
as in-migrants, 87, 282
mental health, 291–293
number in Midtown and Manhattan populations, 87, 283
as type O and Type N, 292

Questionnaire for Home Survey Interview, committee on, 39–40
content of, 40–43
development of, 39–40
preparations, 60–63
qualifying considerations, 64–66
rating, 63–64
(*See also* Methods of Home Interview Survey)

Raines, G. N., 407
Raskin, A. H., 359
Reciprocal demographic variables, 17–20
marital status, 175–176
religious affiliation, 304, 339
rural-urban origin, 18–20, 339–340
socioeconomic mobility factor, 225
socioeconomic status, own, 200–201
Redlich, F. C., 12, 23, 24, 152, 208, 209, 237, 239, 241, 243, 252, 257, 369, 370, 382, 413
Reed, H. H., 86
Religiosity, parental, 307–313
Religious affiliation groups, 304, 339
hospital patients, New York State, 301
total patients, Midtown, 302–303
New Haven, 301
Religious mobility, 313–315
Religious origin groups, defined, 304, 347
help-need and patient-history variable, 315–320
among immigrants, 79
as independent variable, 18–19, 304, 339
mental health distributions, 304–307, 347
professional orientation, 316–320
(*See also* Catholic group; Jewish group; Protestant group)
Rennie, Thomas A. C., 9, 12, 32, 38, 40, 49, 59, 62, 63, 129, 134–136, 168, 336–337, 378–379, 407
Research, for etiology of disease, 9, 22
error potentials in, 340
large vs. small projects, 340
Reymont, P., 262, 280
Riessman, F., Jr., 208
Rittwagen, M., 165, 172, 173
Roberts, Bertram H., 281, 317–318, 322, 324
Rohrer, J. H., 407
Role continuity and discontinuity, defined, 164, 170
of immigrants, 255, 357–358
prevention of, 361
Roper, Elmo, 4
Rose, A. M., 251, 281, 369
Rosow, Irving, 189
Roth, J., 207
Roth, William F., 5, 7, 188
Rowntree, L. G., 236
Rubinstein, E. A., 54
Ruesch, J., 217, 238, 239
Rural-urban origin, in ethnic groups, 285
in generation-in-U.S. groups, 261–268
as reciprocal variable, 18–20, 339–340
Russell, A. L., 58

Sabghir, F., 207
Salisbury, Harrison E., 123
Salt Lake City sample, morbidity rate, 141
Sample design of Home Survey, 32–36, 54
age distribution by sex, 36
comparisons of three Midtown samples, 383–387
nonparticipation, 35, 55
population universe specified, 32–33, 36
Sanford, Fillmore H., 146, 155, 337, 367, 371
Sarason, S. B., 57
Sargent, H., 154
Sartwell, P. E., 135, 154
Saslow, G., 57
Saveth, E. N., 254, 279
Schroeder, C. W., 251
Schwartz, Richard D., 370
Scientific humanism, 367
Seeley, J. R., 54, 57, 371
Segmental institutions in Midtown, 107–110, 116
Selection for migration, subjective and objective, 262, 280
Self-hatred in generation II, 255–256
Selvin, H. C., 54
Service programs, planning, 273

Sex factor, female-male ratio, 81–82, 88, 102, 180–182, 384
in generation-in-U.S. group, 280
previous studies, 175, 211
socioeconomic status, parental, 218
Shanas, E., 251
Sharp, H., 55
Shepherd, M., 335
Shevky, E., 54, 88
Simon, Katherine, 7
Singer, J. L., 208
Slums, children of, 198–200
housing, 114
Smith, M. Brewster, 371
Snyder, C. R., 323
Social change, cultural revolution and, 362–363
mental health and, 366
Social psychiatry, community focus, 13–14
focus on entire mental health range, 21–22
fundamental postulate, 12–13
interdisciplinary collaboration, 6
methods of, 6–7
pioneer figures in, 12
scientific convergences, clinical psychiatry, 11–12
medical epidemiology, 10–11
social sciences, 12–14, 16
social science questions, 367
Social Science Research Council (SSRC), 12, 269–273
Social scientists on socioeconomic mobility, 223–224
Sociocultural realm, and age stresses, 170
change and parental religiosity, 313
demographic variables, 17, 19, 20, 339
dysfunctions, historical trends, 359–362
family functioning, 19–20, 354, 358–359
mental health, historical trends, 362–364
Socioeconomic status, age factor, 218–222
biogenic determinants, 328–330
children, consequences, 194–200, 234
cultural revolution, differential effects, 362–364
errors, artifacts and bias, 411–413
family functioning, 192–193, 196–201, 355–358
fundamentals of, 190–193
and generation-in-U.S. groups, 257–258
measurements, 201–205
mental health distributions, 210–236, 328, 346
mental health hypotheses, 200, 206
Socioeconomic status, metropolitan variants, 194
mobility and, 222–229
morbidity, previous over-all, studies of, 211–212, 221
of national origin groups, 285, 290–293, 295–296
in New Haven study, 200, 241–244
open and closed systems, 193
parental and own socioeconomic status, 18–19, 200–204, 339
patient-history variable, 246–247
professional orientation, 200–204, 247–248, 339
psychiatric attention, effects by, 248–249
somatic disorders, 195
symptoms, trends by, 216–218
Treatment Census rates, 240–251
treatment facilities, low-cost, high-cost, 244
zones by Sick-Well ratios, 232–236
Sociography operation, objective and methods, 28–29, 69
Sociologists, in Midtown Study, 48–50, 64, 69
orientation of, 327–329
perspectives of, 116, 354–356
research, 12–14, 16, 135, 190–191, 337
in retrospect, 336–337
Somatic disorders, 5, 40–41
and age factor, 163–164, 166, 332–333
children and, 195
etiological patterns of, 15–16
investigation of, 135
predispositions, 16–17
socioeconomic status and, 195–196
Soviet Russia, 203, 370
Spectorsky, A. C., 103
Spiegelman, M., 371
Spinley, B. M., 208
Srole, L., 54, 87, 123, 172, 206, 208, 279, 298, 324
Stainbrook, E., 19, 20, 25
Star, Shirley, A., 4–5, 57, 407
Statistical approach, 24, 27–28, 340–341
Status system in U.S. and England, 360–361
Steffens, Lincoln, 261
Steinbeck, John, 92, 93, 100, 103, 118, 120, 123
Stokes, J., III, 382
Stone, Gregory P., 207
Stouffer, S. A., 54, 55, 57, 58, 155, 172, 238, 281
Strauss, A. L., 84, 298
Suarez, Amorita, 324
Suarez, Joseph, 299

Subcommittee on Health and Sciences, House of Representatives, 337
Subjective selectivity, defined, 262, 280
and Puerto Ricans, 293
Suburbia, exodus from New York City to, 97–98
movement to, 103
Suicide rates, 112, 113, 136–137
among Jewish population, 306, 319
Sullivan, Frank, 12, 102, 117
Supply and demand levels, treatment facilities, 131, 352–353
Symptom-formation classification, 138–139, 341–342
Symptoms, nature of, interpersonal functioning, 42
intrapsychic functioning, 42
socioeconomic status, 216–218

Taft, R., 58
Taran, Frieda, 30
Taubman, H., 102
Tawney, R. H., 360, 370
Thomas, Dorothy S., 269, 281
Thomas, W. I., 279
Tietze, C., 5
Tillich, P. J., 366, 371
Treatment Census, and age groups, 158–159
compared to Home Interview Survey, 133, 268–269
function of, 338–339, 349–350
generation-in-U.S. groups, 268, 273–274
on hospital patients, permanent, 243–244
incidence and prevalence as yardsticks, 30–31, 281, 380–382
marital status, 174, 186
Midtown inclusive, 127–132
objectives and methods, 28–31
patients' prevalence rates, 240–245, 281, 380–382
religious groups, 300–303
compared to New Haven study, 301–302
sex groups, 174
socioeconomic status, 204–205, 240–245, 251
compared to New Haven study, 241–245, 251
Treatment facilities, bottlenecks, 132
Catholic ambulatory, 320
demands, effective and dormant, 352–353
determining need for, 5–6
expansion of plans for, 273–274
low-cost need, 245
Treatment facilities, Manhattan hospitals, clinics, and office therapists, 105, 107, 127–129
New Haven study, 132
program research, 8–9, 22
supply and demand, 352–353
treated and untreated traffics, 353–354
Tuberculosis morbidity rates in New York City, 112, 113
Tunnard, C., 86
Twain, Mark, 95–96, 103
Tyhurst, T. S., 172

U.S. Census Bureau, on annual incomes (1900–1950), 359
on criteria for metropolitan area, 84
on employment and schooling, 239
on Midtown population, 80, 282
objective sampling of, 33–34
on religious affiliations, 47
urban population defined by, 87
U.S. immigration laws, 260–261, 263, 280, 348
U.S. Immigration and Naturalization Service, 280
U.S. National Health Surveys, 58, 135, 154, 207, 211, 370, 382
U.S. Supreme Court, 1954 school desegregation decision, 366
University of Michigan Survey Research Center, 239
Unmarried status, morbidity rates, 178–186
population, Midtown, 81
rejected type, 180
self-chosen type, 180
unchosen type, single women, 180–182

Value conflicts and psychopathology, 200
Variables, demographic (*see* Demographic variables)
Voluntary organizations in Midtown, 107, 115–116

Wages, community involvement in scale, 356
laws for minimum, 359–360
substandard, 359–360
(*See also* Income, family)
Wagner, Robert F., 123
Warner, W. Lloyd, 54, 87, 190–191, 193, 201, 206–209, 279, 298
Waugh, Alec, 91, 102, 120, 124
Wechsler, Israel S., 303
Wecter, D., 85
Weider, Arthur, 42, 56

Well mental health category, age factor in, 160–161
generation-in-U.S., 257–258, 262
national origin, 290–295
occupational mobility, 226–228
religious origin, 304–305, 310–312
religious mobility, 314–315
sex and marital status, 176, 185–186
socioeconomic status, parental and own, 213–216, 219, 229, 230–232
urban origin, 267–268
White, E. B., 90, 100, 121, 124
White-collar class, in closed and open systems, 193
and cultural revolution, 363–364
among immigrants, 260
income increases for, 359
mental health of, 232–233
National Health Survey of 1936, 211
need to live in Midtown, 97
occupational mobility, 227–228
Whitehorn, John, 23
Whyte, W. H., Jr., 98, 103
Wilder, Thornton, 70, 121
Williams, M., 54, 88
Williams, Robin, 207
Winslow, C. E. A., 23
Wittson, C. L., 137
Wohl, R. R., 84
Wolfe, Thomas, 91–92, 102
Women, cultural revolution and, 363
employed, 81–82, 183
mental health composition of, 164–165, 176–181
single, living in Midtown, 81, 182–183
Woodward, Luther E., 7
Woollcott, Alexander, 100, 103
Wright, Frank Lloyd, 92, 102, 121
Wynder, E. L., 24

Yale University School of Medicine, 131
Yankee City investigation, 190–191
Yarrow, M. R., 281

Zborowski, M., 324
Zilboorg, Gregory, 23
Znaniecki, F., 279
Zorbaugh, H., 86
Zubin, Joseph, 154, 407
Zwerling, I., 164, 172

(Continued from front flap)

team of social scientists and psychiatrists. Not the famous skyline, or Broadway, or Wall Street, or Madison Avenue is the point of descriptive focus, but a wholly residential area near the epicenter of the Island. Midtown, as this area is here called, houses 100,075 people who are a cross-section of Manhattan's resident 1.4 million non-Puerto Rican white population.

Applying a battery of research methods that have been previously used only on smaller cities and towns, the authors go behind the facades of Midtown's towering Gold Coast apartment houses and congested slum tenements to reveal what the area is like as a place to live, what kinds of people choose to make their homes here, and what manner of a community and psychological climate they create. At the center of the delineated research picture are the mental health conditions, in their broad-spectrum variety, found among their diverse groups that comprise Midtown's patchwork population. Compared in their mental health make-up are younger and older adults, men and women, the single and the married, immigrants and the American-born, the major nationality groups and Old Americans, Catholics, Protestants, and Jews, the rich, the poor, and economic shades inbetween. Spanning this range are corporation executives and doctors, career women and housewives, shopkeepers and taxi drivers, factory workers, domestics, and the unemployed.

Identified in all these groups are not only the conditions clinically known to psychiatrists, but also the state of mental well-being and the sub-clinical varieties of symptomatic distress. Moreover, among those people needing professional help the authors find gross intergroup differences in seeking and securing the help that is needed.

Eight years in the making, the Midtown Study exposes a seam of life in the American metropolis never before penetrated to such depth. It uncovers some hitherto unrecognized or neglected social problems that pose a challenge to the self-correcting capacities of the nation. Such a dissection of democracy's unfinished business has not been offered since *The American Dilemma,* Myrdall's great work on racial discrimination. As the authors phrase it, "Here, in mental health terms, is America's own Displaced Persons problem."

UNIVERSAL
LIBRARY

116 203

UNIVERSAL
LIBRARY